Alaska Medical Assistance Program

ALASKA ELECTRONIC HEALTH RECORDS Incentive Program

10/2011

Provider Manual

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1 Background

The Centers for Medicare & Medicaid Services (CMS) has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to eligible professionals (EP) and eligible hospitals (EH), including critical access hospitals (CAHs), participating in Medicare and Medicaid programs who adopt, implement, upgrade, or meaningfully use certified Electronic Health Records (EHR) technology. Under ARRA, states are responsible for identifying professionals and hospitals that are eligible for these Medicaid EHR incentive payments, making payments, and monitoring use of the payments. The incentive payments are not a reimbursement, but are intended to encourage EPs and EHs to adopt and meaningfully use certified EHR technology.

Use of certified EHR systems is required to qualify for incentive payments. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at www.healthit.hhs.gov .

Goals for the national program include:

- Enhance care coordination and patient safety;
- Reduce paperwork and improve efficiencies;
- Facilitate electronic information sharing across providers, payers, and state lines; and
- Enable data sharing using state Health Information Exchange (HIE) and the National Health Information Network (NHIN). Achieving these goals will improve health outcomes, facilitate access, simplify care, and reduce costs of health care nationwide.

Resources:

- 7 AAC 165 – Alaska Medicaid Electronic Health Records Incentive Program
- 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule
- Alaska State Medicaid HIT Plan (SMHP)
- www.cms.gov/EHRIncentivePrograms
- www.HealthIT.hhs.gov

List of Acronyms

AAC=Alaska Administrative Code	HIE=Health Information Exchange
ARRA=American Recovery and Reinvestment act of 2009	HIT=Health Information Technology
AIU=Adopt, Implement, Upgrade (certified EHR Technology	IHS=Indian Health Service
CAH=Critical Access Hospital	MMIS=Medicaid Management Information Systems
CCN=CMS Certification Number	NAAC=Net Average Allowable Cost
CFR=Code of Federal Regulations	NHIN=National Health Information Network
CHIP=Children's Health Insurance Program	NPI=National Provider Identifier
CMS=Centers for Medicare & Medicaid Services	ONC=Office of National Coordinator for Health Information Technology
CPOE=Computerized Physician Order Entry	POS=Place of Service
CY=Calendar Year	PQRI=Physician Quality Reporting Initiative
EHR=Electronic Health Records	RHC=Rural Health Clinic
EH=Eligible Hospital	SLR=State Level Registry
EP=Eligible Professional	SMHP=State Medicaid Health Information Technology Plan
FFY=Federal Fiscal Year	SSN=Social Security Number
FQHC=Federal Qualified Health Center	TIN=Tax Identification Number
FY=Fiscal Year	

2 How Do I use this manual?

The Alaska Electronic Health Records Incentive Program Provider Manual is a resource for healthcare professionals and hospitals who wish to learn more about the Alaska Medicaid EHR Incentive Program including detailed information and resources on eligibility and attestation criteria. These manual provides details on how to apply for program incentive payments via the Alaska Medicaid State Level Registry (SLR), which is the Department's web-based EHR Incentive Program application system.

The best way for a new user to orient themselves to the EHR Incentive Program requirements and processes is to read through each section of this manual in its entirety prior to starting the application process.

This manual is organized by EHR Incentive program eligibility requirements, patient volume methodology, program payment methodology, meaningful use quality measures and program registration requirements for both EPs and EHs and SLR application process.

3 How do I get help?

If you have any questions or problems, please contact the Health Information Technology, EHR Incentive Program Office. EHR Incentive Program Office is the central point-of-contact to aid providers in enrolling in the Alaska Medicaid EHR Incentive Program and providing education and outreach to all Alaska Medical Assistance enrolled providers.

Address: 1835 Bragaw, Suite 300, Anchorage, Alaska 99508

Email Address: hss.hitinfo@alaska.gov

There are a number of resources available to assist providers with the Alaska Medicaid EHR Incentive Program application process. These resources can be found at: http://ak.arraincentive.com/.

4 Eligible provider types

Per the federal rule, EPs must begin participation in the program no later than calendar year (CY) 2016 and EHs must begin by federal fiscal year (FFY) 2016. The following Alaska Medical Assistance providers and out-of-state providers who are enrolled in Alaska Medical Assistance are eligible to participate in the Alaska Medicaid EHR Incentive Program.

Eligible professionals

- physician (MD and DO)
- dentist
- certified nurse-midwife
- nurse practitioner
- physician assistant practicing in a Federally Qualified Health Center (FQHC) led by a physician assistant or a rural health clinic (RHC), that is so led by a physician assistant

For the purposes of the EHR Incentive Program a Tribal clinic is considered a FQHC. A physician assistant practicing in a Tribal clinic must meet the same requirements of a physician assistant practicing in a FQHC. Any other provider that practices in a Tribal clinic follows the same rules as a FQHC.

Physician Assistant (PA) led Federally Qualified Health Clinic (FQHC) or Rural Health Clinic (RHC) means a PA is:

- the primary provider in a clinic (for example, when there is a part-time physician and full-time PA, we would consider the PA as the primary provider);
- a clinical or medical director at a clinical site of practice; or
- an owner of an RHC.

Eligible hospitals

- Acute care hospitals, including critical access hospitals (CAHs)
- Children's hospitals

5 Enrollment requirements

Requirements for an eligible professional

To qualify for an EHR incentive payment for each year the EP seeks the incentive payment, the EP must meet the following criteria:

- Meet one of the following patient volume criteria:
  - Have a minimum of 30 percent patient volume attributable to individuals receiving Title XIX Medicaid funded services; or
  - Have a minimum 20 percent patient volume attributable to individuals receiving Title XIX Medicaid funded services, and be a pediatrician*; or
  - Practice predominantly in a FQHC or RHC and have a minimum 30 percent patient volume attributable to needy individuals
- Have a valid contract with Alaska Medical Assistance**;
- Have no sanctions and/or exclusions;
- Not hospital-based (hospital based is defined as 90% or more of services are performed in a hospital inpatient or emergency room setting)

* For the purposes of this program, the Department defines pediatricians as a practitioner who is board certified through the American Board of Pediatrics web site ***or*** through the American Osteopathic Board of Pediatrics.

** A valid contract means that the provider is currently enrolled with Alaska Medical Assistance to provide services. An individual EP may choose to receive the incentive him/herself or assign it to a Medicaid contracted clinic or group to which he/she is associated. The tax identification number (TIN) of the individual or entity receiving the incentive payment is required when registering with the Centers for Medicare and Medicaid EHR Incentive Program Registration and Attestation System. The TIN of the individual or entity receiving the incentive payment must match a TIN linked to the individual provider in the Medicaid Management Information System (MMIS). For entities that do not link providers to their MMIS enrollment, the provider must be in contractual arrangement with the group or clinic to which they assign their payment.

Hospital-based providers are not eligible for the Alaska Medicaid EHR Incentive Program. Other providers and hospitals that are currently ineligible for the Alaska Medicaid EHR Incentive Program include behavioral health (substance abuse and mental health) providers and facilities and long-term care providers and facilities. Note that some provider types eligible for the Medi*care* program, such as chiropractors, are not eligible for the Alaska Medicaid EHR Incentive Program per federal regulations.

Requirements for an eligible hospital

To qualify for an EHR incentive payment for each year the EH seeks the incentive payment, the EH must meet the following criteria:

- An acute care hospital including Critical Access Hospitals (CAH)
  - Acute Care and Critical Access Hospitals must have:
    - Medicaid discharges of at least 10% for the Medicaid patient volume,
    - An average Length of Stay (LOS) of 25 days or less,
    - A CCN that ends in 0001 – 0879 or 1300 – 1399 to be eligible to receive an incentive payment
- A children's hospital

- Children's Hospitals with a CCN that ends in 3300 – 3399 do not have to meet the patient volume threshold.

Qualifying providers by provider type and patient volume

Provider Types	Patient Volume over 90-days Period
Eligible Hospital	
Acute Care Hospital (includes Critical Assess Hospitals)	• 10% Medicaid
Children's Hospital	• No Medicaid volume requirement
Eligible Professional	
Physicians (M.D., D.O.)	• 30% Medicaid • For EPs practicing in a FQHC/RHC - 30% Needy Individuals
Dentists	
Certified Nurse Midwives	
Nurse Practitioners	
PAs when practicing at an FQHC/RHC that is led by a PA	
Pediatrician	• 30% Medicaid • If Pediatrician patient volume = 20-29%, the provider may qualify for 2/3 of incentive payment

Out-of-state providers

The Alaska Medicaid EHR Incentive Program allows out-of-state provider to participate in this advantageous program. Out-of-state providers have the same eligibility requirements as in-state providers. Alaska must be the only state they are requesting an incentive payment from during that participation year. For audit purposes, out-of-state providers must make available any and all records, claims data, and other data pertinent to an audit by either the Alaska Department of Health and Social Services or Centers for Medicare and Medicaid Services. Records must be maintained as applicable by law in the State of practice or Alaska, whichever is deemed longer. The out of state provider must be enrolled with Alaska Medical Assistance in order to participate in the Alaska Medicaid EHR Incentive Program.

6 Patient volume methodology

A Medicaid provider must annually meet patient volume requirements for the Alaska Medicaid EHR Incentive Program as established through the State's CMS approved SMHP. Patients' funding source identifies who can be counted in the patient volume: Title XIX – Medicaid or Title XXI – Children's Health Insurance Program (CHIP).

Eligible professional patient encounter calculation

EP patient volume for those not practice predominantly in a Federally Qualified Health Center (FQHC), Rural Health Center (RHC) or Tribal clinic will be calculated based on Title XIX Medicaid and out-of-state Medicaid patients. For EPs practicing predominantly in a FQHC or RHC the patient volume is calculated using the needy individual patient volume requirements. Practicing predominantly is defined as an EP practicing at an FQHC or a RHC clinical location for over 50 percent of his or her total patient encounters over a period of 6 months.

The EP Medicaid patient volume or needy individual patient volume is calculated based on the number of encounters for a selected 90 day or greater period in the previous calendar year.

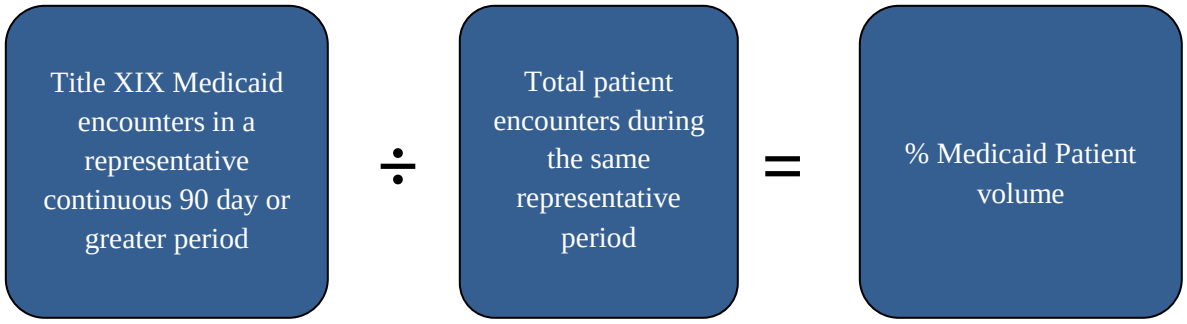
Eligible professional Medicaid encounter

For purposes of calculating the EP patient volume, a Medicaid encounter is defined as services rendered on any one day to an individual where Title XIX Medicaid or another State's Medicaid program paid for:

- Part or all of the service; or
- Part or all of their premiums, co-payments, and/or cost-sharing.

To calculate Title XIX Medicaid patient volume, an EP must divide:

1. The total Title XIX Medicaid or out of-state Medicaid patient encounters in any representative, continuous 90-day or greater period in the preceding calendar year; by
2. The total patient encounters in the same 90-day or greater period.



Eligible professional needy individual encounter

For purposes of calculating the patient volume for an EP practicing predominantly in an FQHC/RHC, a needy individual encounter is defined as services rendered on any one day to an individual where medical services were:

- Paid for by Title XIX Medicaid or Title XXI Children's Health Insurance Program, funding including Alaska Medical Assistance Program, out-of-state Medicaid programs or a Medicaid or CHIP demonstration project approved under section 1115 of the Act;
- Furnished by the provider as uncompensated care, or **
- Furnished at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

**For providers practicing in a Tribal clinic, uncompensated care is a calculated figure, using charity care and bad debt to determine the number of encounters that are considered uncompensated care. Indian Health Services (IHS) has defined uncompensated care as:

Total Visits - Paid Visits (regardless of payer)* - Charity Care (special fund that people qualify for [this is 0 for Tribes/Urban]) – Bad Debt = Uncompensated Care.

*Under the paid visits figure IHS is not considered a payer.

To calculate needy individual patient volume, an EP must divide:

1. The total needy individual patient encounters in any representative, continuous 90-day or greater period in the preceding calendar year; by
2. The total patient encounters in the same 90-day or greater period.

Group practice patient encounter calculation

Clinics or group practices will be permitted to calculate patient volume at the group practice/clinic level, but only in accordance with all of the following limitations:

- The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP;
- There is an auditable data source to support the clinic's or group practice's patient volume determination;
- All EPs in the group practice or clinic must use the same methodology for the payment year;
- The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way; and
- If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EPs outside encounters.

The group patient volume for a non-Federally Qualified Health Center (FQHC), Rural Health Center (RHC) or Tribal clinic will be calculated based on Title XIX Medicaid and out-of-state Medicaid patients. The group patient volume for a FQHC, RHC or Tribal clinic is calculated using the needy individual patient volume requirements if the providers within the group practiced predominantly in the FQHC, RHC or Tribal clinic in the previous calendar year.

Group Medicaid encounters

To calculate the group practice patient volume, a group must divide:

1. The total Title XIX Medicaid or out of-state Medicaid patient encounters in any representative, continuous 90-day or greater period in the preceding calendar year; by
2. The total patient encounters in the same 90-day or greater period.

Group needy individual encounters

In order for providers to use the group needy individual patient volume, all providers within the group must have practiced predominantly in the FQHC, RHC or Tribal clinic for 50% of their encounters over a 6 month time period in the previous calendar year.

To calculate the group needy individual patient volume, a group must divide:

1. The total group needy individual patient encounters in any representative, continuous 90-day or greater period in the preceding calendar year; by
2. The total patient encounters in the same 90-day or greater period.

Eligible hospital patient encounter calculation

For purposes of calculating EH patient volume, a Medicaid encounter is defined as services rendered to an individual (1) per inpatient discharge, or (2) on any one day in the emergency room where Title XIX Medicaid or another State's Medicaid program paid for:

- Part or all of the service;
- Part or all of their premiums, co-payments, and/or cost-sharing;

In order for emergency room encounters to count towards the patient volume the emergency department must be part of the hospital.

Exception **-** A children's hospital is not required to meet Medicaid patient volume requirements.

To calculate Title XIX Alaska Medicaid patient volume, an EH must divide:

1. The total Title XIX Alaska Medicaid and out-of-state Medicaid encounters in any representative 90-day or greater period in the preceding fiscal year; by
2. The total encounters in the same 90-day or greater period.
    a. Total number of inpatient discharges for the selected 90-day or greater period; the encounters also include discharges within the 90 days in which the patient was admitted prior to the start of the selected 90-day or greater period plus could include the total number of emergency department visits in the same 90-day or greater period.

7 Electronic health record functions

Adopt, Implement or Upgrade (AIU)

Adopt, Implement or Upgrade (AIU). Federal regulations allow EPs and EHs who participate in the Alaska Medicaid EHR Incentive Program to receive incentive payments if they adopt, implement or upgrade to a certified EHR technology in the first year of participation. (This option is not available through the Medicare Incentive Program in which all providers must meet meaningful use in the first year.) At the time of attestation, the EP or EH will be required to provide documentation supporting the claim of AIU, such as a contract or paid invoice.

What does Adopt, Implement or Upgrade Mean?	
Adopt	Acquire, purchase, or secure access to certified EHR technology
Implement	Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements;
Upgrade	Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria.

Meaningful Use (MU)

Meaningful Use (MU) of EHR technology is a major goal of this program. CMS has determined that MU will be rolled out in three stages. The current rule provides specific information on Stage 1 which focuses heavily on establishing the functionalities in certified EHR technology that will allow for continuous quality improvement and ease of information exchange. They include:

- Electronically capturing health information in a structured format;
- Using that information to track key clinical conditions and communicating that information for care coordination purposes (whether that information is structured or unstructured, but in structured format whenever feasible);
- Implementing clinical decision support tools to facilitate disease and medication management;
- Using EHRs to engage patients and families; and
- Reporting clinical quality measures and public health information.

Though some functionalities are optional in Stage 1, as outlined in discussions later in this manual, all of the functionalities are considered crucial to maximize the value to the health care system provided by certified EHR technology. CMS encourages all EPs and EHs to be proactive in implementing all of the functionalities of Stage 1 in order to prepare for later stages of meaningful use, particularly functionalities that improve patient care, the efficiency of the health care system and public health. Current federal regulations indicate that providers practicing in multiple locations must provide meaningful use data only for locations that utilize certified EHR technology.

Adopt, Implement, Upgrade in Year 1

EPs who adopt, implement, or upgrade in their first year of participation do not have to report meaningful use during the first payment year. In the second year of participation, EPs must display meaningful use for a selected 90 day reporting period. Providers must report a full year of meaningful use for all other subsequent payment years. Payment years do not have be consecutive until 2016. EPs who display meaningful use of EHR technology in the first year of participation must report 90 days of meaningful use, all other subsequent years provider must report a full calendar year.

EP AIU or MU Payments				
	2011 First Year EP Receives Payment	2012 First Year EP Receives Payment	2013 First Year EP Receives Payment	2014 First Year EP Receives Payment
CY 2011	AIU			
	No MU reporting period required			
CY 2012	Stage 1 MU	AIU		
	Display MU for a selected 90 day period	No MU reporting period required		
CY 2013	Stage 1 MU	Stage 1 MU	AIU	
	Display MU for a 1 calendar year period	Display MU for a selected 90 day period	No MU reporting period required	
CY2014	Stage 2 MU	Stage 1 MU	Stage 1 MU	AIU
	Display MU for a 1 calendar year period	Display MU for a 1 calendar year period	Display MU for a selected 90 day period	No MU reporting period required

Display Meaningful Use in Year 1

EP MU Payments				
	2011 First Year EP Receives Payment	2012 First Year EP Receives Payment	2013 First Year EP Receives Payment	2014 First Year EP Receives Payment
CY 2011	Stage 1 MU			
	Display MU for a selected 90 day period			
CY 2012	Stage 1 MU	Stage 1 MU		
	Display MU for a 1 calendar year period	Display MU for a selected 90 day period		
CY 2013	Stage 2 MU	Stage 1 MU	Stage 1 MU	
	Display MU for a 1 calendar year period	Display MU for a 1 calendar year period	Display MU for a selected 90 day period	
CY2014	Stage 2 MU	Stage 2 MU	Stage 1 MU	Stage 1 MU
	Display MU for a 1 calendar year period	Display MU for a 1 calendar year period	Display MU for a 1 calendar year period	Display MU for a selected 90 day period

Stage 1 Meaningful Use criteria

If an EH received an incentive payment for AIU in the first year of participation in the Alaska Medicaid EHR Incentive Program, they will need to successfully demonstrate meaningful use of certified EHR technology in the second year of participation for a selected 90 day reporting period in the Federal fiscal year. The reporting period for all subsequent years will be the entire Federal fiscal year.

EPs do not need to successfully demonstrate meaningful use in their first year of participation in order to receive an incentive payment. The reporting period in the second calendar year of participation is 90 days during the calendar year. The reporting period for all remaining calendar years will be the entire calendar year.

To meet Stage 1 meaningful use criteria, EPs and EHs must meet all core objectives and five from the menu set of objectives, with at least one being a public health objective (denoted by the asterisk). A particular objective may be excluded if the following criteria are met:

- Meets the criteria in the applicable objective that would permit the attestation; and
- Attests that the objective is not applicable.
- Exclusions may apply to certain measures; these exclusions are identified within each measure. An exclusion reduces the number of objectives that otherwise apply. For instance, an EP that qualifies for the exclusion of an objective from the menu set will be required to select only four from the menu set. The EP must still report at least one of the public health objectives.

Following are the elements for the core and menu sets organized by EP and EH requirements.

Stage 1-Eligible professional quality measures

Meaningful Use Reporting Measures

Eligible Professionals report on 20 of 25 measures	
• Core Set – all 15 measures	• Menu Set – 5 of 10 including 1 public health measure

Eligible Professional Core Measures		
EPs must report on all 15 of the below Core Measures		
Objective	**Measure**	**Exclusion**
1) Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	1) More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.	1) Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
2) Implement drug-drug and drug-allergy interaction checks.	2) The EP has enabled this functionality for the entire EHR reporting period.	2) No exclusion.
3) Maintain an up-to-date problem list of current and active diagnoses.	3) More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.	3) No exclusion.
4) Generate and transmit permissible prescriptions electronically (eRx).	4) More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.	4) Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
5) Maintain active medication list.	5) More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	5) No exclusion.
6) Maintain active medication allergy list.	6) More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	6) No exclusion.
7) Record all of the following demographics: a. Preferred language	7) More than 50 percent of all unique patients seen by the EP have demographics recorded as	7) No exclusion.

b. Gender c. Race d. Ethnicity e. Date of birth	structured data.	
8) Record and chart changes in the following vital signs: a. Height b. Weight c. Blood pressure d. Calculate and display body mass index (BMI) e. Plot and display growth charts for children 2-20 years, including BMI	8) For more than 50 percent of all unique patients age 2 and over seen by the EP, height, weight, and blood pressure are recorded as structured data.	8) Any EP who either sees no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice.
9) Record smoking status for patients 13 years old or older.	9) More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.	9) Any EP who sees no patients 13 years or older.
10) Report ambulatory clinical quality measures to the CMS or, in the case of Medicaid EPs, the State of Alaska. ***(See Clinical Quality Measures Table)***	10) Successfully report to CMS or to the State of Alaska ambulatory clinical quality measures.	10) No exclusion.
11) Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.	11) Implement one clinical decision support rule.	11) No exclusion.
12) Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request.	12) More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days.	12) Any EP who has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.
13) Provide clinical summaries for patients for each office visit.	13) Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.	13) Any EP who has no office visits during the EHR reporting period.
14) Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.	14) Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.	14) No exclusion.

15) Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	15) Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	15) No exclusion.
Eligible Professional Menu Set Measures		
EPs must report on 5 of the 10 Menu Set Measures; at least 1 public health measure must be selected		
Objective	**Measure**	**Exclusion**
1) Implement drug formulary checks.	1) The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.	1) Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
2) Incorporate clinical lab test results into EHR as structured data.	2) More than 40 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.	2) An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.
3) Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	3) Generate at least one report listing patients of the EP with a specific condition.	3) No exclusion.
4) Send reminders to patients per patient preference for preventive/follow-up care.	4) More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.	4) An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.
5) Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.	5) At least 10 percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EPs discretion to withhold certain information.	5) Any EP that neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy list (or

		other information as listed at 45 CFR 170.304(g)) during the EHR reporting period.
6) Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	6) More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources.	6) No exclusion.
7) The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	7) The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.	7) An EP who was not the recipient of any transitions of care during the EHR reporting period.
8) The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.	8) The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.	8) An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.
9) Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice. ***PH*Measure**	9) Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically).	9) An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.
10) Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice. ***PH* Measure**	10) Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically).	10) An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically.

Meaningful Use Clinical Quality Measures (CQMs)

There are no performance thresholds implied; the requirement is that these measures be reported for Stage 1, not that they meet a specific value.

- EPs must report on 3 required CQMs. If the denominator of 1 or more of the required core measures is zero, then EPs are required to report results for up to 3 alternate core measures
- EPs must also select 3 additional CQMs from a set of 38 specialty measures
- **In sum, EPs must report on 6 total measures: 3 required core measures (substituting alternate core measures when necessary) and 3 additional measures**

Eligible Professionals Core Clinical Quality Measures			
Core Measures	**Description of Clinical Quality Measure**	**Source – PQRI[1]**	**Source – NQF[2]**
Must Report These 3 Core Clinical Quality Measures			
1) Hypertension: Blood Pressure Measurement	Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.		0013
2) A) Tobacco Use Assessment & B) Tobacco Cessation Intervention	(A) Percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months (B) Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.		0028
3) Adult Weight Screening and Follow-up	Percentage of patients ages 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical records AND if the most recent BMI is outside parameters, a follow-up plan is documented. (must report 2 numerators and denominators)	128	0421
Note: If the denominator of 1 or more of these **Core Clinical Quality Measures** is zero, the eligible professional must report up to 3 **Alternate Core Measures**, with a total of 3 Core Clinical Quality Measures which could include the Alternative Core Measures			
Alternate Core Measures			
4) Weight Assessment & Counseling for Children and Adolescents	Percentage of patients 2-17 years of age who had an outpatient visit with a Primary Care physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year. (must report 9 numerators and denominators)		0024

5) Influenza Vaccination for Pts >50 yrs	Percentage of patients aged 50 years and older who received n influenza immunization during the flu season (September through February).	110	0041
6) Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps, and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. (must report 12 numerators and denominators)		0038

[1] PQRI - Physician Quality Reporting Initiative Measures List: http://www.cms.gov/PQRI/Downloads/2010_PQRI_MeasuresList_111309.pdf

[2] NQF - National Quality Forum Measures List: http://www.qualityforum.org/Measures_list.aspx

Eligible Professionals Specialty Clinical Quality Measures

Must Report 3 of These Specialty Clinical Quality Measures

Additional Specialty Menu Measures	Source – PQRI[1]	Source – NQF[2]
1) Pneumonia Vaccination for Patients 65 Years and Older	111	0043
2) Screening Mammography	112	0031
3) Colorectal Cancer Screening	113	0034
4) Cervical Cancer Screening		0032
5) Chlamydia screening in women (must report 3 numerators and denominators)		0033
6) Controlling High Blood Pressure		0018
7) Asthma: Pharmacologic Therapy	53	0047
8) Asthma assessment	64	0001
9) Use of appropriate medications for people with asthma (must report 3 numerators and denominators)		0036
10) Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control(must report 2 numerators and denominators)		0075
11) Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	117	0055
12) Diabetes Mellitus: Urine Screening for Microalbumin	119	0062
13) Diabetes Mellitus: Hemoglobin A1c Poor Control	1	0059
14) Comprehensive Diabetes Care: HbA1c Control (<8.0%)		0575
15) Diabetes Mellitus: Foot Exam	163	0056

16) Diabetic Retinopathy: Documentation of Retinopathy	18	0088
17) Diabetes Mellitus: High Blood Pressure Control	3	0061
18) Communication with the Physician Managing On-going Care	19	0089
19) Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (must report 2 numerators and denominators)	2	0064
20) Oral Antiplatelet Therapy Prescribed for Patients with CAD	6	0067
21) Beta-Blocker Therapy for CAD Patients with Prior MI	7	0070
22) Beta-Blocker Therapy for Left Ventricular Dysfunction (LVSD)	8	0083
23) Drug Therapy for Lowering LDL-Cholesterol	197	0074
24) Warfarin Therapy for Patients with Atrial Fibrillation	200	0084
25) Blood Pressure Management Control	201	0073
26) Use of Aspirin or Another Antithrombotic	204	0068
27) ACE Inhibitor or ARB for Left Ventricular Dysfunction (LVSD)	5	0081
28) Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	71	0387
29) Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients	72	0385
30) Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients	102	0389
31) Major Depression: (a) Effective Acute Phase Rx Treatment and (b) Continuation (must report 2 numerators and denominators)	9	0105
32) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement (must report 6 numerators and denominators)		0004
33) Prenatal Screening for Human Immunodeficiency Virus (HIV)		0012
34) Prenatal Anti-D Immune Globulin		0014
35) Appropriate Testing for Children with Pharyngitis	66	0002
36) Low back pain: use of imaging studies		0052
37) Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	12	0086
38) Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit (must report 2 numerators and denominators)	115	0027
For the Clinical Quality Measure Description and Measure Specification information go to *http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage*		

Stage 1-Eligible hospital quality measures

Meaningful Use Reporting Measures

Eligible Hospitals report on 19 of 24 measures	
• Core Set – all 14 measures	• Menu Set – 5 of 10 including 1 public health measure

Eligible Hospital Core Measures		
EHs must report on all 14 of the below Core Measures		
Objective	**Measure**	**Exclusion**
1) Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than 30 percent of all unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE.	No exclusion.
2) Implement drug-drug and drug-allergy interaction checks.	The eligible hospital or CAH has enabled this functionality for the entire EHR reporting period.	No exclusion.
3) Maintain an up-to-date problem list of current and active diagnoses.	More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data.	No exclusion.
4) Maintain active medication list.	More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	No exclusion.
5) Maintain active medication allergy list.	More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	No exclusion.
6) Record all of the following demographics:	More than 50 percent of all unique patients admitted	No exclusion.

a. Preferred language b. Gender c. Race d. Ethnicity e. Date of birth f. Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH	to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data.	
7) Record and chart changes in the following vital signs: a. Height b. Weight c. Blood pressure d. Calculate and display body mass index (BMI) e. Plot and display growth charts for children 2-20 years, including BMI	For more than 50 percent of all unique patients age 2 and over admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight, and blood pressure are recorded as structured data.	No exclusion.
8) Record smoking status for patients 13 years old or older.	More than 50 percent of all unique patients 13 years old or older or admitted to the eligible hospital's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data.	Any eligible hospital or CAH that admits no patients 13 years or older to their inpatient or emergency department (POS 21 or 23).
9) Report hospital clinical quality measures to CMS or, in the case of Medicaid eligible hospitals, the State of Alaska. ***(See Clinical Quality Measures Table)***	Successfully report to CMS or to the State of Alaska hospital clinical quality measures.	No exclusion.
10) Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule.	Implement one clinical decision support rule.	No exclusion.
11) Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures) upon request.	More than 50 percent of all patients of the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days.	Any eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.
12) Provide patients with an electronic copy of their discharge instructions at time of discharge, upon	More than 50 percent of all patients who are discharged from an eligible hospital or CAH's	Any eligible hospital or CAH that has no requests from

request.	inpatient or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it.	patients or their agents for an electronic copy of the discharge instructions during the EHR reporting period.
13) Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.	No exclusion.
14) Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	No exclusion.
Eligible Hospital Menu Set Measures		
EHs must report on 5 of the 10 Menu Set Measures; at least 1 public health measure must be selected		
Objective	**Measure**	**Exclusion**
1) Implement drug formulary checks.	The eligible hospital or CAH has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.	No exclusion.
2) Record advance directives for patient 65 years old or older.	More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient (POS 21) have an indication of an advance directive status recorded as structured data.	An eligible hospital or CAH that admits no patients age 65 years old or older during the EHR reporting period.
3) Incorporate clinical lab test results into EHR as structured data.	More than 40 percent of all clinical lab test results ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.	No exclusion.
4) Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the eligible hospital or CAH with a specific condition.	No exclusion.

5) Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources.	No exclusion.
6) The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The eligible hospital or CAH performs medication reconciliation for more than 50 percent of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).	No exclusion.
7) The eligible hospital or CAH that transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.	The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.	No exclusion.
8) Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically).	An eligible hospital or CAH that administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.
9) Capability to submit electronic data on reportable (as required by State or local law) lab results to public health agencies and actual submission according to applicable law and practice. ***PH*Measure**	Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an eligible hospital or CAH submits such information has the capacity to receive the information electronically).	No public health agency to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically.
10) Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice. ***PH*Measure**	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an eligible hospital or CAH submits such information has the capacity to receive the information electronically).	No public health agency to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically.

Meaningful Use Clinical Quality Measures (CQMs)

There are no performance thresholds implied; the requirement is that these measures be reported for Stage 1, not that they meet a specific value.

Eligible Hospital Clinical Quality Measures			
Eligible hospitals and CAHs must report on all 15 of their clinical quality measures.			
Clinical Quality Measure	**Description of Clinical Quality Measure**	**Source – NQF[2]**	**Source**
1) Emergency Department Throughput-Admitted patients Median time from ED arrival to ED departure for admitted patients	Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department.	0495	ED-1
2) Emergency Department Throughput-admitted patients Admission decision time to ED departure time for admitted patients	Median time from admit decision time to time of departure from the emergency department of emergency department patients admitted to inpatient status.	0497	ED-2
3) Ischemic stroke-Discharge on Antithrombolytic Therapy	Ischemic stroke patients prescribed antithrombolytic therapy at hospital discharge.	0435	Stroke-2
4) Ischemic stroke-Anticoagulation Therapy for Atrial Fibrillation Flutter	Ischemic stroke patients with atrial fibrillation/flutter who are prescribing anticoagulation therapy at hospital discharge.	0436	Stroke-3
5) Ischemic stroke-Thrombolytic therapy for patients arriving within 2 hours of symptom onset	Acute ischemic stroke patients who arrive at this hospital within 2 hours of time last known well and for whom IV t-PA was initiated at this hospital within 3 hours of time last know well.	0437	Stroke-4
6) Ischemic or hemorrhagic stroke-Antithrombotic therapy by day 2	Ischemic stroke patients administered antithrombotic therapy by the end of hospital day 2.	0438	Stroke-5

7) Ischemic stroke-Discharge on statin medication	Ischemic stroke patients with LDL ≥ = 100mg/dL, or LDL not measured, or, who were on lipid-lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge.	0439	Stroke-6
8) Ischemic or hemorrhagic stroke-Stroke education	Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke.	0440	Stroke-8
9) Ischemic or hemorrhagic stroke-Rehabilitation assessment	Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services.	0441	Stroke-10
10) Venous Thromboembolism (VTE) prophylaxis within 24 hours of arrival	This measure assesses the number of patients who received VTE prophylaxis or have documentations why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.	0371	VTE-1
11) Intensive Care Unit VTE prophylaxis	This measure assesses the number of patients who receive VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the intensive Care Unit (ICU) or surgery end date for surgeries that started the day of or the day after ICU admission (or transfer).	0372	VTE-2
12) Anticoagulation overlap therapy	This measure assesses the number of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they must be discharged on both medications. Overlap therapy must be administered for at least five days with an international normalized ratio (INR) ≥2 prior to discontinuation of the parenteral anticoagulation therapy or the patient must be discharged on both medications.	0373	VTE-3

13) Platelet monitoring on unfractionated heparin	This measure assesses the number of patients diagnosed with confirmed VTE who received intravenous (IV) UFH therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol.	0374	VTE-4
14) Venous Thromboembolism (VTE) discharge instructions	This measure assesses the number of patients diagnosed with confirmed VTE that are discharged to home, to home with home health, home hospice or discharged/transferred to court/law enforcement on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions/interactions.	0375	VTE-5
15) Incidence of potentially preventable VTE	This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present on arrival) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.	0376	VTE-6

[2] NQF - National Quality Forum Measures List: http://www.qualityforum.org/Measures_list.aspx
HITSP Quality Measure Technical Note ED, VTE, and Stroke Examples
http://www.hitsp.org/ConstructSet_Details.aspx?&PrefixAlpha=5&PrefixNumeric=906
For the Clinical Quality Measure Description and Measure Specification information go to
http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage

Stage 2 and 3 Meaningful Use criteria

Stage 2: The objective for Stage 2 MU criteria is to expand upon the Stage 1 MU to encourage the use of health information technology for continuous quality improvement at the point of care and the exchange of information in the most structured format possible, such as the electronic transmission of orders entered using CPOE and the electronic transmission of diagnostic test results (such as blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, pulmonary function tests, genetic tests, genomic tests and other such data needed to diagnose and treat disease).

It is expected that Stage 2 MU use requirements will include rigorous expectations for health information exchange, including more demanding requirements for e-Prescribing and incorporating structured laboratory results and the expectation that providers will electronically transmit patient care summaries to support transitions in care across unaffiliated providers, settings and EHR systems. Increasingly robust expectations for health information exchange in Stage 2 and Stage 3 will support and make real the goal that information follows the patient.

CMS has indicated that more information about Stage 2 MU will be released at a later date.

Stage 3: The goals for the Stage 3 MU criteria are to focus on promoting improvements in quality, safety and efficiency leading to improved health outcomes, focusing on decision support for national high priority conditions, patient access to self management tools, access to comprehensive patient data through robust, patient-centered health information exchange and improving population health. (More information to be released at a later date.) CMS has indicated that more information about Stage 3 MU will be released at a later date.

8 Enrollment process

In order for providers to meet the qualifications for the Alaska Medicaid EHR Incentive Program providers are required to attest that the information submitted in their application is true and accurate.

In order for an EP to qualify for an incentive payment in a particular calendar year they must have completed their attestation in the SLR within 60 days of the close of the calendar year to count towards that payment year (calendar year). Hospital are paid on a federal fiscal year, hospitals must submit their attestation in the SLR within 60 days of the close of the federal fiscal year (October 1-September 30) to count towards that payment year. For example an EH may complete their attestation by November 30.

Program attestation preparation

1. Register at the Centers for Medicare and Medicaid Registration and Attestation System at https://ehrincentives.cms.gov/hitech/login.action.
2. Create a SLR account at http://ak.arraincentive.com/.
3. Locate a copy of your signed contract with a vendor for the purchase, implementation or upgrade of a certified EHR system.
4. Verify your EHR is certified and is on the list from ONC at http://onc-chpl.force.com/ehrcert.
5. EPs must locate your active medical license number and Medicaid ID.
6. EHs must locate the most recent 4 years of cost report data.
7. Determine your Medicaid patient volume you will be reporting for the selected 90 days or greater period.
8. Determine which method of certified EHR technology you will be attesting to - adopt, implement, upgrade or meaningful use.
9. Complete the Eligibility workbook and Adopt/Implement/Upgrade Attestation workbook.
10. Complete the application in the SLR and sign and complete the attestation.

Medicare and Medicaid Registration and Attestation System

Both EPs and EHs are required to begin by registering at the national level with the Centers for Medicare and Medicaid EHR Incentive Program Registration and Attestation System.

EPs registering in the Medicaid EHR Incentive Program must enter their National Plan and Provider Enumeration System (NPPES) web user account, user ID and password to log into the registration system. EPs may choose to receive the incentive payment themselves or assign them to a clinic or group to which they belong. The EP must select where their payment will go in the payee TIN type. EPs must provide the SSN payee TIN type to indicate that the provider receives the payment. The EIN payee TIN type indicated the group receives the incentive payment. Providers will have to enter the group name, group payee TIN and the group NPI in order for the provider to issue the payment to the group in which they are associated. In order for the group or clinic to receive the incentive payments from Alaska, the EP must have a billing provider contract to which the payment is being assigned.

EPs must select between the Medicare and Medicaid incentive programs (Prior to 2015 a provider may switch programs once after receiving an incentive payment). If Medicaid is selected, the provider must choose only one state (EPs may switch states annually). Providers must revisit the CMS Registration and Attestation System to make any changes to their information and/or choices, such as changing the program from which they want to receive their incentive payment.

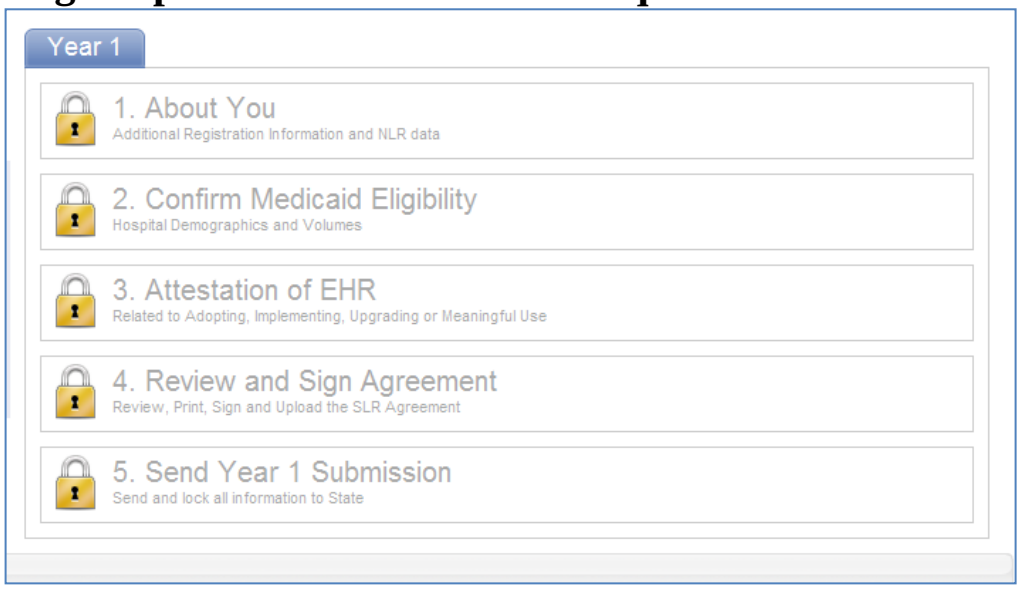
Hospital representative must enter their Identification and authentication User ID and Password to log into the Centers for Medicare and Medicaid EHR Incentive Program Registration and Attestation System. Hospitals must provide their CCN and the NPI for the hospital. The hospital must select the Medicaid state and the hospital type in which they will participate.

EHs seeking payment from both Medicare and Medicaid will be required to visit the Medicare and Medicaid EHR Incentive Program Registration and Attestation System annually to attest to meaningful use before returning to SLR website to complete the attestation for Alaska's Medicaid EHR Incentive Program. Alaska Medicaid will assume meaningful use is met for hospitals deemed so for payment from the Medicare EHR Incentive Program.

The Medicare and Medicaid EHR Incentive Program Registration and Attestation System will electronically notify the Alaska Medicaid SLR of a provider's choice to enroll in the Alaska Medicaid EHR Incentive Program. The information completed by the provider at the national website is sent to the SLR electronically within 24-48 hours.

Alaska Medicaid State Level Registry

Eligible professional attestation requirement for AIU



1-About You

The EP will be asked:
☐ I attest that I DO NOT perform 90% of more of my services in an inpatient hospital or emergency room setting.
The EP will also be asked:
☐ I attest that I am a pediatrician and am eligible for a reduced incentive payment if I achieve 20% Medicaid eligibility. ☐ I attest that I am a Physician Assistant that practices predominantly in a PA led FQHC or RHC.
The EP must:
☐ Enter their Alaska Medicaid Provider ID number ☐ Identify if they practice in a Tribal Health Program or other federal clinic without an Alaska License o If Yes: ✓ Enter the Licensing Board Name ✓ Other State License Number ✓ Other License State o If No: ✓ Enter the Alaska Professional License Number ✓ Enter the Licensing Board Name ☐ Enter the contact person information o Name, phone number and email address

2-Confirm Medicaid Eligibility

The EP must:
☐ Select a 90 day or greater period to enter their patient encounter information to establish the patient volume calculation. ☐ If you select: o 90 day period-you must select the start date of the selected 90 day period

- Full calendar year period-you must enter the start date of January 1st of the previous calendar year
- Other period-the period must be greater than 90 day and must be within the previous calendar year

☐ Enter the Total Encounters for the selected 90 day or greater period
☐ Enter the Total Medicaid Encounters for the same selected 90 day or greater period
☐ Identify if the provider practice in more than one state
- If Yes:
  - ✓ Identify if they want their volumes for all states to be used to determine eligibility
    - If Yes:
      - EPs must enter the State, Total Encounters, Total Medicaid Encounters for that state
      - You must also enter Alaska encounter data and enter the Total Encounters, Total Medicaid Encounters for Alaska Medicaid
- Note: These totals must match the total encounters and Medicaid encounters originally entered for the selected representative period

☐ Identify if they practice predominantly in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)
- If Yes:
  - ✓ The needy individual patient volume may only be used if the provider practices predominantly in a Federally Qualified Health Center or Rural Health Clinic

3-Attestation of EHR-Criteria Method and Certified EHR Technology

The EP must select the Criteria Method in which they will attest:

☐ Adopt ☐ Implement ☐ Upgrade
☐ The EP must enter a brief description of how they meet the criteria for adopting, implementing or upgrading to certified EHR Technology
☐ A document that shows proof of purchase of the certified EHR Technology must be uploaded in the SLR, provider must select a subject of contract in order to complete their attestation

The EP must:

☐ Identify that they understand it is their responsibility to ensure that their EHR technology is listed on the Office of National Coordinator for Health Information Technology, Certified Health IT Product List
☐ Enter the CMS EHR Certification ID
- Note: The CMS EHR Certification ID is not the same as the Certified Health IT Product List (CHPL) Product number

4-Review and Sign Agreement

Attestation agreement

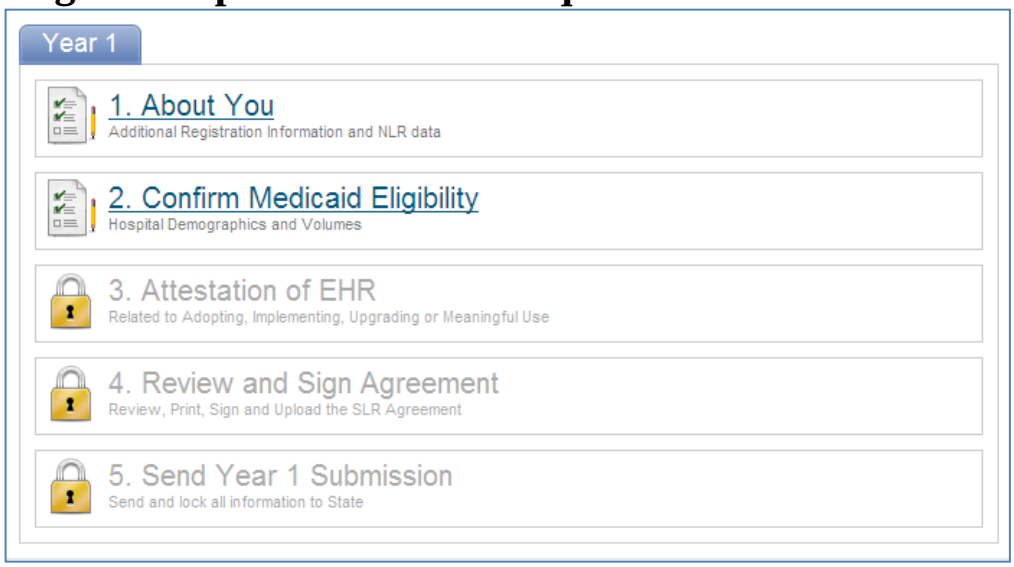
☐ The EP must review and sign the completed attestation agreement and must ensure all information entered is true and accurate
☐ The signed attestation agreement must be uploaded back into the SLR
☐ You are required to send the originally signed attestation agreement to the Alaska Medicaid EHR Incentive Program Office

5-Send Year 1 Submission

Complete attestation

☐ Enter submit to complete the submission process in the SLR

Eligible hospital attestation requirement for AIU



1-About You

The EH will be asked to:
☐ Enter the contact person information o Name, phone number and email address

2-Confirm Medicaid Eligibility

The EH must:
☐ Select a 90 day or greater period to enter their patient encounter information to establish the patient volume calculation. ☐ If the hospital selects a period of: o 90 day period - you must select the start date of the selected 90 day period o Hospital FY ending in the prior Federal FY- you must enter the start date of the hospital fiscal year, the hospital fiscal year must end in the previous federal fiscal year o Previous Federal F - (10/1-09/30) o Other period - the period must be greater than 90 days and must be within the previous federal fiscal year
☐ Enter the Total Discharges for the selected 90 day or greater period ☐ Enter the Total Medicaid Discharges for the same selected 90 day or greater period ☐ Identify if the hospital has Medicaid patients in more than one state o If Yes: ✓ Identify if they want their volumes for all states to be used to determine eligibility • If Yes: o EHs must enter the State, Total Discharges, Total Medicaid Discharges for that state
o You must also enter Alaska Discharge data and enter the Total Discharges, Total Medicaid Discharges for Alaska Medicaid Note: These totals must match the total discharges and Medicaid discharges originally entered for the selected representative period ☐ Enter the Average Length of Stay, in days, for the hospital fiscal year that ends during the prior federal fiscal year. Excluding swing and nursery bed days.

3-Attestation of EHR-Criteria Method and Certified EHR Technology

The EP must select the Criteria Method in which they will attest:
☐ Adopt ☐ Implement ☐ Upgrade ☐ The EH must enter a brief description of how they meet the criteria for adopting, implementing or upgrading to certified EHR Technology ☐ A document that shows proof of purchase of the certified EHR Technology must be uploaded in the SLR, hospitals must select a subject of contract in order to complete their attestation
The EP must:
☐ Identify that it is their responsibility to ensure that their EHR technology is listed on the Office of National Coordinator for Health Information Technology, Certified Health IT Product List ☐ Enter the CMS EHR Certification ID o Note: The CMS EHR Certification ID is not the same as the Certified Health IT Product List (CHPL) Product number

4-Review and Sign Agreement

Attestation agreement
☐ The EH authorized representative must review and sign the completed attestation agreement to ensure all information entered is true and accurate ☐ The signed attestation agreement must be uploaded back into the SLR ☐ You are required to send the originally signed attestation agreement to the Alaska Medicaid EHR Incentive Program Office

5-Send Year 1 Submission

Complete attestation
☐ Enter submit to complete the submission process in the SLR

Hospital cost report data fields

Note that you will be requested to enter a variety of data from your cost reports into the SLR.

<table>
<tr><td>Representative Period</td><td colspan="2">You must select a representative 90 day or greater period. This field is where you will enter the start date and or end date of the period that you have chosen to determine your Medicaid patient volume.</td></tr>
<tr><td>Total Discharges for the Representative Period</td><td colspan="2">These are your total discharges for all payers, including Medicaid, for the representative period that you have chosen to determine eligibility.</td></tr>
<tr><td>Medicaid Discharges for the Representative Period</td><td colspan="2">These are your total Medicaid “encounters” for the representative period that you have chosen to determine eligibility.</td></tr>
<tr><td>Location On Cost Report - CMS 2552-96 cost report data fields</td><td colspan="2">When totals are requested for inpatient bed days and discharges, theses totals must NOT include nursery or swing bed counts.</td></tr>
<tr><td>Average Length of Stay</td><td colspan="2">Your Average Length of Stay can be calculated using data reported in your most recently filed cost report. The most recently filed costs report is defined as the hospital cost report ending prior to the start of the current federal fiscal year

Total Inpatient Bed Days (S-3, Part I, Column 6 listed as "Total All Patients", line 12-sum of acute care inpatient)
Total Discharges (S-3, Part I, Column 15 listed as "Total All Patients", line 12-sum of acute care inpatient)</td></tr>
<tr><td rowspan="4">Prior Year Discharges Data</td><td colspan="2">Discharge data from 4 prior years is used to calculate the growth rate for your hospital. Alaska has designated your most recently filed cost report for the period ending prior to the start of the current federal fiscal year plus the filed cost reports for the three years preceding it. A number is required in all fields. You may not enter a zero.

(S-3, Part I, Column 15 listed as "Total All Patients", line 12-sum of acute care inpatient)</td></tr>
<tr><td colspan="2">As listed in the SLR, if the date of your most recently filed Cost Report is 2010:

Year 4 is 2007
Year 3 is 2008
Year 2 is 2009
Year 1 is 2010</td></tr>
<tr><td>Location On Cost Report - CMS 2552-96 cost report data fields</td><td>Location on SLR’s Confirm Alaska Medicaid Eligibility Page</td></tr>
<tr><td>Discharges</td><td>S-3, Part I, Column 15 listed as "Total All Patients", line 12-sum of acute care inpatient</td><td>Lines 1 and 2

Total Discharges</td></tr>
<tr><td>Medicaid Inpatient Bed Days</td><td>S-3, Part I, Column 5 listed as "Total Title XIX", line 12-sum of acute care inpatient</td><td>Line 3 Total Medicaid Inpatient Bed Days</td></tr>
</table>

Total Medicaid Managed Care Inpatient Bed Days	Alaska does not have Medicaid Managed Care Inpatient Bed Days; it is included in the hospital calculation sheet only because it is a data field in the SLR. Hospitals may enter a "0" in this field in the SLR.	Line 4 Total Medicaid Managed Care Inpatient Bed days
Total Inpatient Bed Days	S-3, Part I, Column 6 listed as "Total All Patients", line 12-sum of acute care inpatient	Line 5 Total Inpatient Bed Days
Total Hospital Charges	Worksheet C, Part I, Column 8 listed as "Total charges", line 101	Line 6 Total Hospital Charges
Total Charity Care ***(as defined for Medicare cost reporting purposes)***	S-10, Line 30, if your cost report does not contain this information determine if the hospital accounting records or hospital financial statements supports the input of charity care charges as defined for Medicare cost reporting purposes, hospitals will be required to provide this financial documentation to the Medicaid EHR Program Office.	Line 7 Hospital Charity Care Charges

Once the electronic attestation is submitted by a qualifying provider and appropriate documentation is provided, the Alaska Medicaid EHR Incentive Program Office will conduct a review to validate that the EP or EH meets the qualifications of the program and will verify supporting documentation.

The attestation itself will require the EP or EH to attest to meeting all requirements defined in the federal regulations. Some documentation will be required to be provided to support specific elements of the attestation. For instance, providers who attest to AIU of certified EHR technology will be required to submit a copy of a signed contract or paid invoice. All providers will be required to mail the originally signed attestation to the Alaska Medicaid EHR Incentive Program Office.

During the first year of the program, EPs or EHs will be able to attest to adopting, implementing or upgrading to certified EHR technology or attest to meaningful use. It should be noted that the documentation for AIU of certified EHR technology for EPs or EHs does not have to be dated in the year of reporting. Documentation dated any time prior to the attestation is acceptable *if the system and version of EHR technology has been certified by ONC* (the Certified Health IT Product List can be located at ONC's website at www.healthit.hhs.gov). All providers will be required to attest to meeting meaningful use to receive incentive payments after the first year.

9 What is the payment methodology?

Payment methodology for eligible professionals

Payment for EPs equals 85 percent of ”net average allowable costs”, or NAAC. NAAC are capped by statute at $25,000 in the first year, and $10,000 for each of 5 subsequent years. NAAC for pediatricians with Alaska Medicaid patient volume between 20-29 percent are capped at two thirds of those amounts respectively. Thus, the maximum incentive payment an EP could receive from Alaska Medicaid equals $63,750, over a period of 6 years, or $42,500 for pediatricians with a 20-29 percent Medicaid patient volume.

Provider	EP	EP-Pediatrician
Patient Volume	30%	20-29%
Year 1	$21,250	$14,167
Year 2	8,500	5,667
Year 3	8,500	5,667
Year 4	8,500	5,667
Year 5	8,500	5,666
Year 6	8,500	5,666
Total Incentive Payments	$63,750	$42,500

Pediatricians may qualify to receive the full incentive if the pediatrician can demonstrate that they meet the minimum 30 percent Medicaid patient volume requirements.

Payments for Medicaid eligible professionals

EP payments will be made in alignment with the calendar year and an EP must begin receiving incentive payments no later than CY 2016. EPs will assign the incentive payments to a tax ID (TIN) in the Centers for Medicare & Medicaid EHR Incentive Program Registration and Attestation System. The TIN must be associated with either the EP him/herself or a group or clinic with which the EP has a contractual relationship. EPs who assign an incentive payment to themselves or to the group or clinic in which the payment will be issued will be required to provide Alaska Medical Assistance with a State of Alaska Substitute Form W-9 to which the payment will be issued.

The State of Alaska substitute W-9 may be found at http://dnr.alaska.gov/parks/grants/rectrail/sub_form_w9.pdf.

The Alaska Medicaid EHR Incentive program does not include a future reimbursement rate reduction for non-participating Medicaid providers. (Medicare requires providers to implement and meaningfully using certified EHR technology by 2015 to avoid a Medicare reimbursement rate reduction.) For each year a provider wishes to receive a Medicaid incentive payment, determination must be made that he/she was a meaningful user of EHR technology during that year, except in year one in which the provider may be eligible to receive an incentive payment for adopting, implementing or upgrading to a certified EHR technology. Medicaid EPs are not required to participate on a consecutive annual basis, however, the last year an EP may begin receiving payments is 2016, and the last year the EP can receive payments is 2021.

Payment Amount for Year:	First Year Medicaid EP Qualifies to Receive Payment 2011	First Year Medicaid EP Qualifies to Receive Payment 2012	First Year Medicaid EP Qualifies to Receive Payment 2013	First Year Medicaid EP Qualifies to Receive Payment 2014	First Year Medicaid EP Qualifies to Receive Payment 2015	First Year Medicaid EP Qualifies to Receive Payment 2016
2011	$21,250	-	-	-	-	-
2012	$8,500	$21,250	-	-	-	-
2013	$8,500	$8,500	$21,250	-	-	-
2014	$8,500	$8,500	$8,500	$21,250	-	-
2015	$8,500	$8,500	$8,500	$8,500	$21,250	-
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017	-	$8,500	$8,500	$8,500	$8,500	$8,500
2018	-	-	$8,500	$8,500	$8,500	$8,500
2019	-	-	-	$8,500	$8,500	$8,500
2020	-	-	-	-	$8,500	$8,500
2021	-	-	-	-	-	$8,500
TOTAL Possible Incentive Payments	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

Maximum Incentive Payments for EPs

In the event that the Department of Health and Social Services determines monies have been paid inappropriately, incentive funds will be recouped and refunded to CMS. Providers may refund the money to the State of Alaska in a lump sum, or an accounts receivable account will be set up for the provider and the overpayment recouped through future payments. The existing practice allows the Department of Health and Social Services to work out an acceptable repayment period.

Payment methodology for eligible hospitals

Statutory parameters placed on Alaska Medicaid EHR Incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. The specifications described in this section are limits to which all States must adhere when developing aggregate EHR hospital incentive amounts for Medicaid-EHs. States will calculate hospitals' aggregate EHR hospital incentive amounts on the federal fiscal year (FFY) to align with hospitals participating in the Medicare EHR incentive program.

Alaska may pay children's hospitals and acute care hospitals up to 100 percent of an aggregate EHR hospital incentive amount made in 3 payments. Section 1905(t)(5)(D) requires that no payments can be made to hospitals after 2016 unless the provider has been paid a payment in the previous year. Prior to 2016, Medicaid incentive payments to hospitals can be made on a nonconsecutive, annual basis. The aggregate EHR hospital incentive amount is calculated using an overall EHR amount multiplied by the Medicaid share.

If a hospital continues to be eligible for participation in the Alaska Medicaid EHR Incentive Program each payment year, the department will pay, as follows, the aggregate amount to that hospital:

(1) in the first year of participation, 50 percent of the aggregate amount;

(2) in second year of participation, 40 percent of the aggregate amount;

(3) in the third year of participation, 10 percent of the aggregate amount.

Alaska is responsible for using auditable data sources to calculate Medicaid aggregate EHR hospital incentive amounts, as well as determining Alaska Medicaid EH incentive payments to those providers. Auditable data sources include:

- Providers' Medicare cost reports;
- State-specific Medicaid cost reports;
- Payment and utilization information from the Alaska MMIS (or other automated claims processing systems or information retrieval systems); and
- Hospital financial statements and hospital accounting records.

For purposes of the Alaska Medicaid EHR hospital incentive program, the overall EHR amount is equal to the sum over 4 years of (I)(a) the base amount (defined by statute as $2,000,000); plus (b) the discharge related amount defined as $200 for the 1,150th through the 23,000th discharge for the first year (for subsequent years, CMS assumes discharges increase by the provider's average annual rate of growth for the most recent 3 years for which data are available per year): multiplied by (II) the transition factor for each year equals 1 in year 1, 3⁄4 in year 2, 1⁄2 in year 3, and 1⁄4 in year 4.

The statute specifies that the payment year is determined based on a Federal fiscal year. Section 1886(n)(2)(C) of the Act provides the Secretary with authority to determine the discharge related amount on the basis of discharge data from a relevant hospital cost reporting period, for use in determining the incentive payment during a Federal fiscal year.

Federal fiscal years begin on October 1 of each calendar year, and end on September 30 of the subsequent calendar year. Hospital cost reporting periods can begin with any month of a calendar year, and end on the last day of the 12th subsequent month in the next calendar year. For purposes of administrative simplicity and timeliness, Alaska will use data on the hospital discharges from the hospital fiscal year that ends during the Federal fiscal year prior to the fiscal year that serves as the first payment year.

The discharge-related amount is $200 per discharge for discharges 1,150 through 23,000. To determine the discharge-related amount for the three subsequent years that are included in determining the overall EHR amount, Alaska will assume discharges for an individual hospital have increased by the average annual growth rate for an individual hospital over the most recent 3 years of available data from an auditable data source. Per federal regulations, if a hospital's average annual rate of growth is negative over the 3 year period, it will be applied as such.

The overall hospital EHR amount requires that a transition factor be applied to each year. This transition factor equals 1 for year 1, ¾ for year 2, ½ for year 3, and ¼ for year 4, as provided for in sections 1886(n)(2)(A) and 1886(n)(2)(E) of the Act, and as incorporated through section 1902(t)(5)(B) of the Act.

The "Medicaid Share", against which the overall EHR amount is multiplied, is essentially the percentage of a hospital's inpatient, non-charity care days that are attributable to Medicaid inpatients. More specifically, the Medicaid share is a fraction expressed:

Estimated Medicaid inpatient-bed days

plus estimated Medicaid managed care inpatient-bed-days;

Divided by;

Estimated total inpatient-bed days multiplied by ((estimated total charges minus charity care charges) divided by estimated total charges).

As indicated in the above formula, the Medicaid share includes both Medicaid inpatient-bed-days and Medicaid managed care inpatient-bed-days.

In addition, because the formula for calculating the Medicaid share requires a determination of charity care charges, Alaska will use the Medicare 2552-96 or the revised Medicare 2552–10, Worksheet S–10 or another auditable data source to determine the charity care portion of the formula. In the absence of sufficient charity care data to complete the calculation, section 1886(n)(2)(D) of the Act, requires the use of uncompensated care data to derive an appropriate estimate of charity care, including a downward adjustment for bad debts. CMS interpreted bad debt to be consistent with the Medicare definition of bad debt as promulgated at § 413.89(b)(1).

Finally, per section 1886(n)(2)(D) of the Act, to the extent there is simply not sufficient data that would allow us to estimate the inpatient bed-days attributable to Medicaid managed care patients, the statute directs that such figure is deemed to equal 0. Likewise, if there is simply not sufficient data for the State to estimate the percentage of inpatient bed days that are not charity care (that is, [estimated total charges— charity care charges]/estimated total charges), the statute directs that such figure is deemed to equal 1. Unlike Medicaid EPs, who must waive rights to duplicative Medicare incentive payments, hospitals may receive incentive payments from both Medicare and Medicaid, contingent on successful demonstration of meaningful use and other requirements under both programs.

The last year that a hospital may begin receiving Medicaid incentive payments is FY 2016. States must make payments over a minimum of 3 years. Additionally, in any given payment year, no annual Medicaid incentive payment to a hospital may exceed 50 percent of the hospital's aggregate incentive payment. Likewise, over a 2-year period, no Medicaid payment to a hospital may exceed 90 percent of the aggregate incentive.

Eligible hospital incentive payment calculation methodology

Calculating the overall incentive payment is a multi-step process and utilizes hospital data on total discharges (excluding nursery discharges) to compute a growth rate which is used to determine projected eligible discharges. A base amount of $2,000,000 is added to the eligible discharge amount and a transition factor is applied to arrive at the overall EHR amount. The overall EHR amount needs to be adjusted for charity care before Medicaid's share can be calculated. The aggregate EHR hospital incentive payment is calculated as the product of the [overall EHR amount] times [the Medicaid Share].
Calculating the overall EHR amount is a multistep process, hospitals are required to provide and attest to the following information for the incentive payment to be calculated:

- Total Inpatient Discharges for the most recent 4 fiscal years
- Total Number of Medicaid Inpatient Bed Days
- Total Number of Inpatient Bed Days
- Total Hospital Charges
- Total Charges for Charity Care

This is an example of the steps that will be followed to calculate incentive payments to EHs.

How the Annual Discharge Data is Used

Step 1: Calculating the Average Annual Growth Rate:

To calculate the average annual growth rate the hospital reports the total discharges for the 4 most recent hospital fiscal year cost reports. Total discharges are the sum of all inpatient discharges (excluding nursery discharges).

Fiscal year	Total Discharges	Calculating Annual Growth Rate	Average Annual Growth Rate
2007	**23,500**	2008 - 2007 ÷ 2007 = Growth Rate 24,700 - 23,500 ÷ 23,500 = 5.11%	5.11 + 4.45 + 4.26 = 13.82 ÷ 3 = 4.61%
2008	**24,700**		
2009	**25,800**	25,800 - 24,700 ÷ 24,700 = 4.45%	
2010	**26,900**	26,900 - 25,800 ÷ 2,5800 = 4.26%	

Average Annual Growth Rate **4.61%**

Step 2: Applying the average annual growth rate to the base number of discharges

The number of discharges for the base year of fiscal year 2010 is multiplied by the average annual growth rate of 4.61% (1.0461) to project the number of discharges over the next 3 years:

Projected Inpatient Discharge			
Fiscal year 2010	Fiscal year 2011	Fiscal year 2012	Fiscal year 2013
26,900			
x 1.0461 →	**28,140**		
	x 1.0461 →	**29,437**	
		x 1.0461 →	**30,794**

Step 3: Determine the number of eligible discharges and multiply by the discharge payment amount

1. For the first through the 1,149th discharge, $0
2. For the 1,150th through the 23,000th discharge, $200 per discharge
3. For any discharge greater than the 23,000th, $0

In this example, discharges for each year were greater than both 1,149 and 23,000, so the maximum number of discharges that can be counted are 21,851 (23,000 – 1,149) which then gets multiplied by the $200 per discharge.

Fiscal year	Calculated Discharges	Eligible Discharges	@ $200 Per Discharge	Eligible Discharge Payments
2010	**26,900** (max 23,000 -1,149)	21,851	x $200	$4,370,200
2011	**28,140**	21,851	x $200	$4,370,200
2012	**29,437**	21,851	x $200	$4,370,200
2013	**30,794**	21,851	x $200	$4,370,200

Step 4: Add the Base Year Amount of $2,000,000 per payment year to the eligible discharges payments

Step 5: Multiply the Medicaid Transition Factor to the Eligible Discharge Payment to arrive at the Overall EHR Amount

The transition factor equals 1 for year 1, ¾ for year 2, ½ for year 3 and ¼ for year 4. All four years are then added together.

Step 4						**Step5**			
Fiscal year	Base Year Amount		Eligible Discharge Payments		Total Eligible Discharge Payments		Transition Factor		Overall EHR Amount
2010	$2,000,000	+	$4,370,200	=	$6,370,200	x	1	=	$6,370,200
2011	$2,000,000	+	$4,370,200	=	$6,370,200	x	.75	=	$4,777,650
2012	$2,000,000	+	$4,370,200	=	$6,370,200	x	.50	=	$3,185,100
2013	$2,000,000	+	$4,370,200	=	$6,370,200	x	.25	=	$1,592,550
						Total EHR Amount			**$15,925,500**

How the Total Number of Medicaid Inpatient Bed Days, Total Inpatient Days, Total Hospital Charges and Total Charity Care Charges are used

Step 6: Calculate the Medicaid Share

The next step requires that the Medicaid Share be applied to the total EHR amount. The Medicaid Share is the percentage of Medicaid inpatient bed-days divided by the estimated total inpatient bed days adjusted for charity care. **Note: All inpatient bed day totals should exclude nursery care.** To calculate the Medicaid Share, the hospital will need to provide the following information from the most recently filed cost report. The most recently filed cost report is defined as the hospital costs report ending prior to the start of the current federal fiscal year.

Total of Medicaid Inpatient Bed Days	**Total Inpatient Days**	**Total Hospital Charges**	**Total Charity Care Charges**
7,251	21,250	$135,500,000	$12,300,000

The ”Medicaid Share”, against which the overall EHR amount is multiplied, is essentially the percentage of a hospital’s inpatient, non-charity care days that are attributable to Medicaid inpatients. More specifically, the Medicaid share is a fraction expressed:

$$\text{Medicaid Inpatient Bed Days} \div \text{Total Inpatient Days} \times \left(\frac{\text{Total Hospital Charges- Charity Care Charges}}{\text{Total Hospital Charges}} \right)$$

(Total Hospital Charges – Charity Care Charges) ÷ Total Hospital Charges = Charity Care Adjustment

Total Hospital Charges – Charity Care Charges		Total Charges less Charity Care Charges		Total Hospital Charges		Charity Care Adjustment
$135,500,000 - $12,300,000	=	$123,200,000	÷	$135,500,000	=	.909

Total Inpatient Days x Charity Care Adjustment

Total Inpatient Days		Charity Care Adjustment		Adjusted Inpatient Days by Charity Care
21,250	x	.909	=	19,316

Medicaid Inpatient Bed Days ÷ Adjusted Inpatient Days

Total of Medicaid Inpatient Bed Days		Adjusted Inpatient Days		Medicaid Share
7,251	÷	19,316	=	.3754
		Medicaid Share Percentage 37.54%		

Step 7: Calculate the Aggregate Incentive Payment Amount

To arrive at the aggregate incentive amount multiply the overall EHR Amount of $15,925,500 by the Medicaid Share of 37.54%.

15,925,500 X .3754 = $5,978,433

Total Incentive Payment Amount	**$5,978,433**

Step 8: Distributed over 3 Incentive Payments

The Department will issue hospital incentive payments in 3 incentive payment amounts. The following illustrates an example of how the payments will be issued in 3 payment years at 50, 40 and 10% respectively. The hospital would need to continue to meet the eligibility requirements and meaningful use criteria in all incentive payment years. Participate does not have to be in consecutive years until 2016.

Incentive Payment Timeline	Payment Amounts
Year 1 - 50%	**$2,989,216.50**
Year 2 - 40%	**$2,391,373.20**
Year 3 - 10%	**$597,843.30**

Payments for Medicaid eligible hospitals

EH payments will be made in alignment with the federal fiscal year and an EH must begin receiving incentive payments no later than FFY 2016. EHs will assign the incentive payments to a tax ID (TIN) in the Centers for Medicare & Medicaid EHR Incentive Program Registration and Attestation System. The hospital in which the payment will be issued will be required to provide Alaska Medical Assistance with a State of Alaska Substitute Form W-9 to which the payment will be issued.

The State of Alaska substitute W-9 may be found at http://dnr.alaska.gov/parks/grants/rectrail/sub_form_w9.pdf.

For each year a hospital wishes to receive a Medicaid incentive payment, a determination must be made that the hospital was a meaningful user of EHR technology during that year, except in year one in which the hospital may be eligible to receive an incentive payment for adopting, implementing or upgrading to a certified EHR technology. Alaska Medicaid will assume meaningful use is met for hospitals deemed so for payment from the Medicare EHR Incentive Program. Medicaid EHs are not required to participate on a consecutive annual basis, however, the last year a hospital may begin receiving payments is 2016, and the last year the hospital can receive payments is 2021.

Alaska Medical Assistance currently requires that all hospitals to submit a valid NPI as a condition of Alaska Medicaid provider enrollment. Each hospital will be enrolled as an Alaska Medical Assistance provider and will therefore, meet the requirement to receive an NPI.

In the event that Department of Health and Social Services determines monies have been paid inappropriately, incentive funds will be recouped and refunded to CMS. Providers may refund the money to the State of Alaska in a lump sum, or an accounts receivable account will be set up for the provider and the overpayment recouped through future payments. The existing practice allows the Department of Health and Social Services to work out an acceptable repayment period.

10 Validation and Approval Process

Requesting payment

Once the attestation is complete the EHR Incentive Program Office will validate that the provider meets all of qualifications for the program.

If additional information is needed to support the attestation, the Alaska Medicaid EHR Incentive Program Office may request any missing or additional information from the provider. If missing or additional information is required, the program office will notify the provider by electronic mail of the specific information needed. A provider must submit the additional information to the program office no later than 30 days after the date of the electronic mail notice. If the provider fails to submit the required information during that period, the department will determine the registration incomplete, although the program office will work with the provider office to complete the application.

Before determining if the provider meets the requirements of the program, the EHR Incentive Program Office will evaluate the facts to which the provider has attested and may request additional information from sources other than the provider to validate the providers attestation submitted.

Upon completion of the attestation process, including submission of the electronic attestation, receipt of required documentation and review and acceptance by the EHR Incentive Program Office, an incentive payment will be approved. The State of Alaska will issue the payment to the tax ID identified in the Centers for Medicare & Medicaid EHR Incentive Program Registration and Attestation System.

If the EHR Incentive Program Office determines that the provider does not meet the requirements of the program the provider will be notified by letter of the reason for denial. The provider will be notified of their right to request an appeal. If a change occurs in the information that the department used to deny participation, or that previously resulted in a failure to receive CMS validation, the provider may submit a new or updated attestation at any time during that payment year.

Administrative Appeals

Administrative appeals of decisions related to the Alaska EHR Incentive Payment program will be handled under the procedures described in the Alaska Medicaid EHR Incentive Program Regulations.

A provider may appeal the department’s decision to do any of the following:

- deny participation in the Alaska Medicaid electronic health records incentive program under 7 AAC 165.030;
- suspend an incentive payment under 7 AAC 165.050;
- require repayment of all or a portion of an incentive payment under 7 AAC 165.050;
- terminate participation in the Alaska Medicaid electronic health record incentive program under 7 AAC 165.050.

To appeal a decision of the program office a provider must submit a written request for a first-level appeal to the EHR Incentive Program Office no later than 30 days after the date of the EHR Incentive Program Office letter denying participation. The request for a first-level appeal must specify the basis upon which the department's decision is challenged and include any supporting documentation. A first-level appeal will be conducted by the supervisor who oversees the health information technology program in the department.

Upon receipt of a request for a first-level appeal, if the department has suspended an incentive payment, the department may continue suspending the payment until a final determination is made regarding the appropriateness of the suspension. The department will notify the provider in writing of the department's first-level appeal decision.

The first level appeal may be sent to:

Department of Health & Social Services
Division of Health Care Services
EHR Incentive Program Office
1835 Bragaw St. Suite 300
Anchorage, AK 99508-3469

A provider who is not satisfied with the first-level appeal decision may request a second-level appeal by submitting a written request to the commissioner no later than 30 days after the date of the first-level appeal decision.

The request for second-level appeal must include:

- a copy of the department's first-level appeal decision;
- a description of the basis upon which the decision is being appealed;
- a copy of the first-level appeal submitted by the provider; and
- any additional supporting documentation that supports the basis upon which the provider is making the appeal.

The commissioner's review of the original appeal record, decision, and any additional material submitted by the provider and the department constitutes the second-level appeal. A decision by the commissioner under this subsection is the final administrative decision of the department. The department will notify the provider of the provider's right to appeal to the superior court under the Alaska Rules of Appellate Procedure.

Program Integrity

The department will conduct regular reviews of attestations and incentive payments. These reviews will be selected as part of our current audit selection process, including risk assessment, receipt of a complaint or incorporation into reviews selected for other objectives. Be sure to keep supporting documentation for information you report for the incentive program.

Payment recoupment

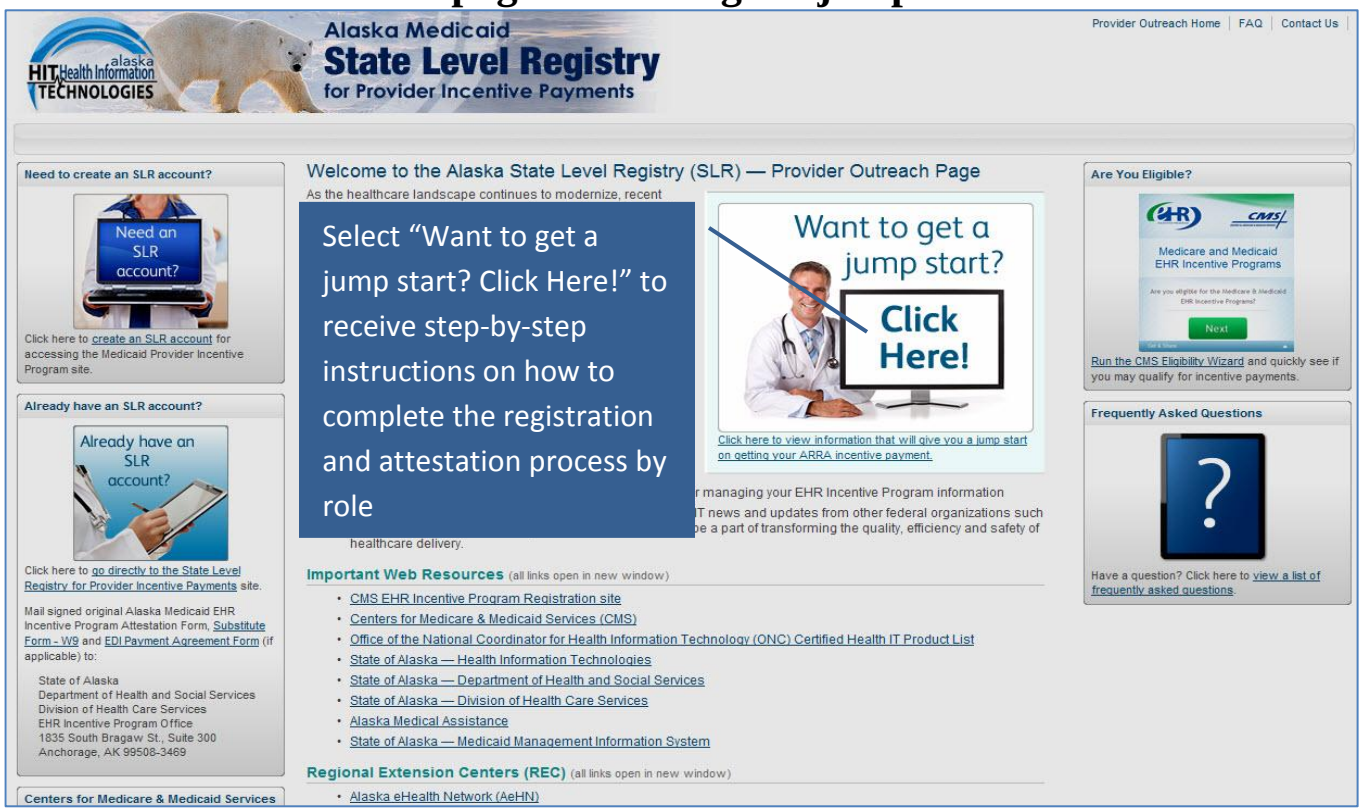
In the event of a recoupment, the provider will be notified by letter of the request for recoupment, along with the provider’s right to appeal the decision. When an erroneous payment occurs which results in an overpayment, repayment options will be discussed with the provider. A provider has an option to refund the full payment in one payment or in multiple segments; the final decision is made by the department. The refund will be made to the State of Alaska. The provider can send payment in full to:

Department of Health & Social Services
Division of Health Care Services
EHR Incentive Program Office
1835 Bragaw St. Suite 300
Anchorage, AK 99508-3469

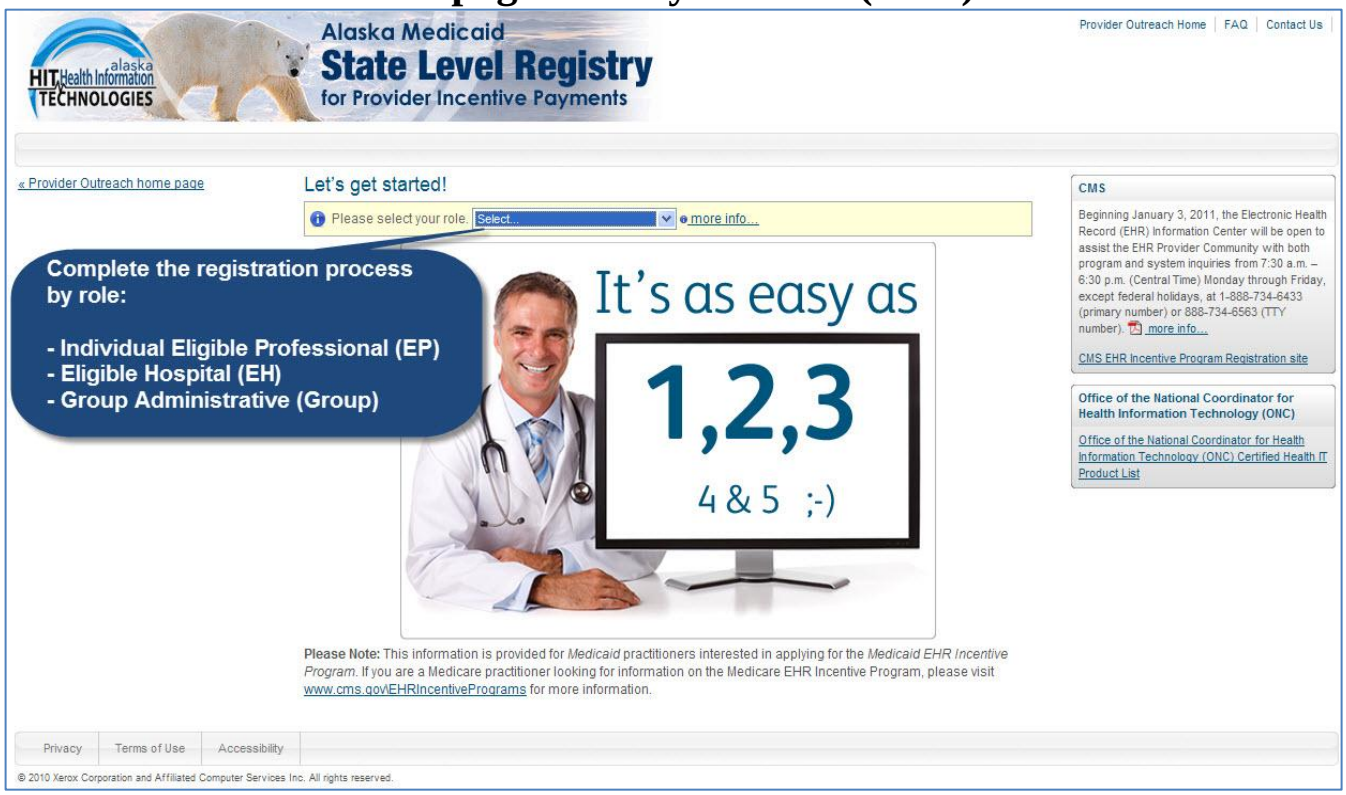
11 State Level Registry Provider Registration

Once the CMS registration information is received in the SLR the provider may complete the registration process in the SLR web portal. The Alaska Medicaid EHR Incentive Program will utilize the secure Alaska Medicaid SLR to house the attestation system.

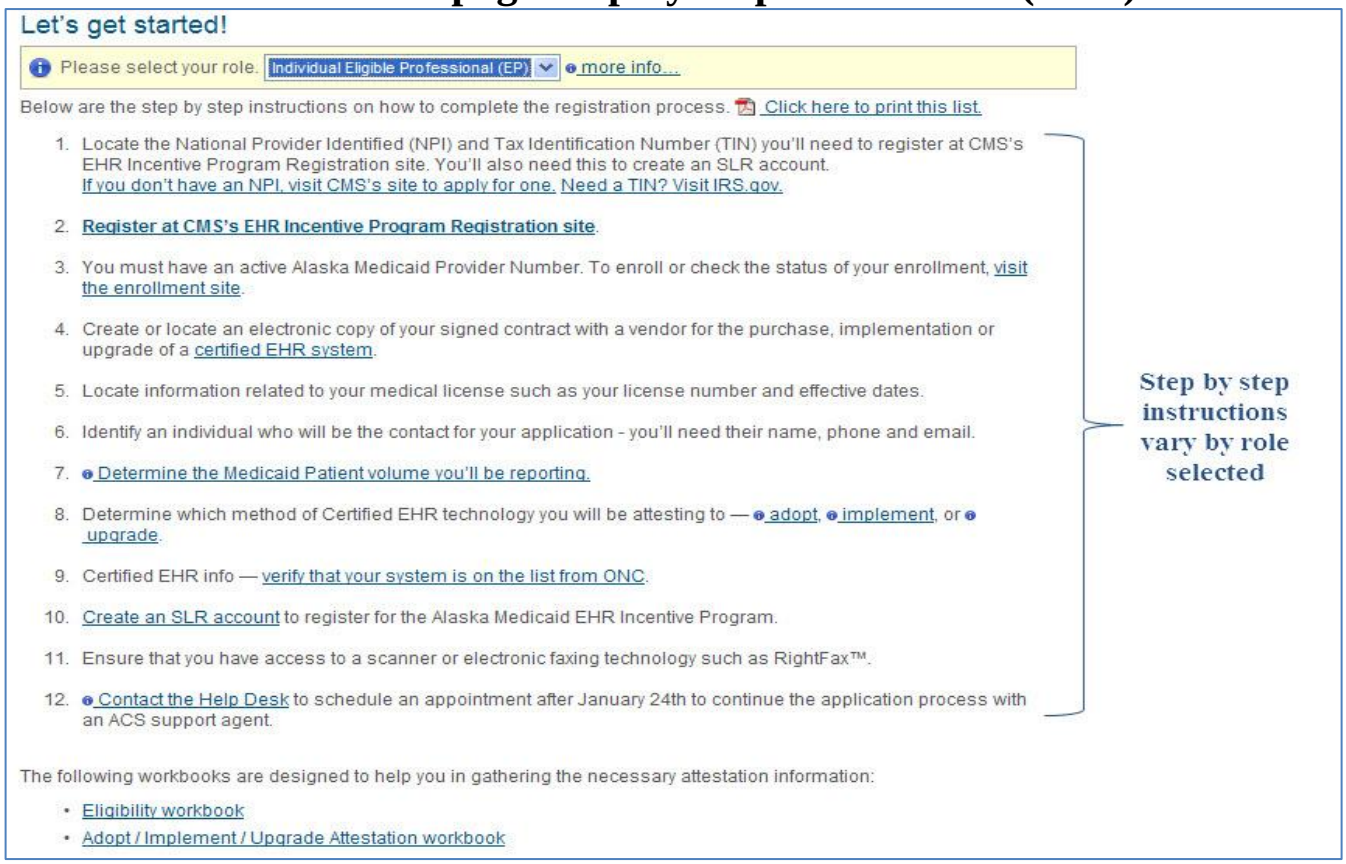
SLR Provider Outreach page -Want to get a jump start?



SLR Provider Outreach page-Select your Role (cont.)

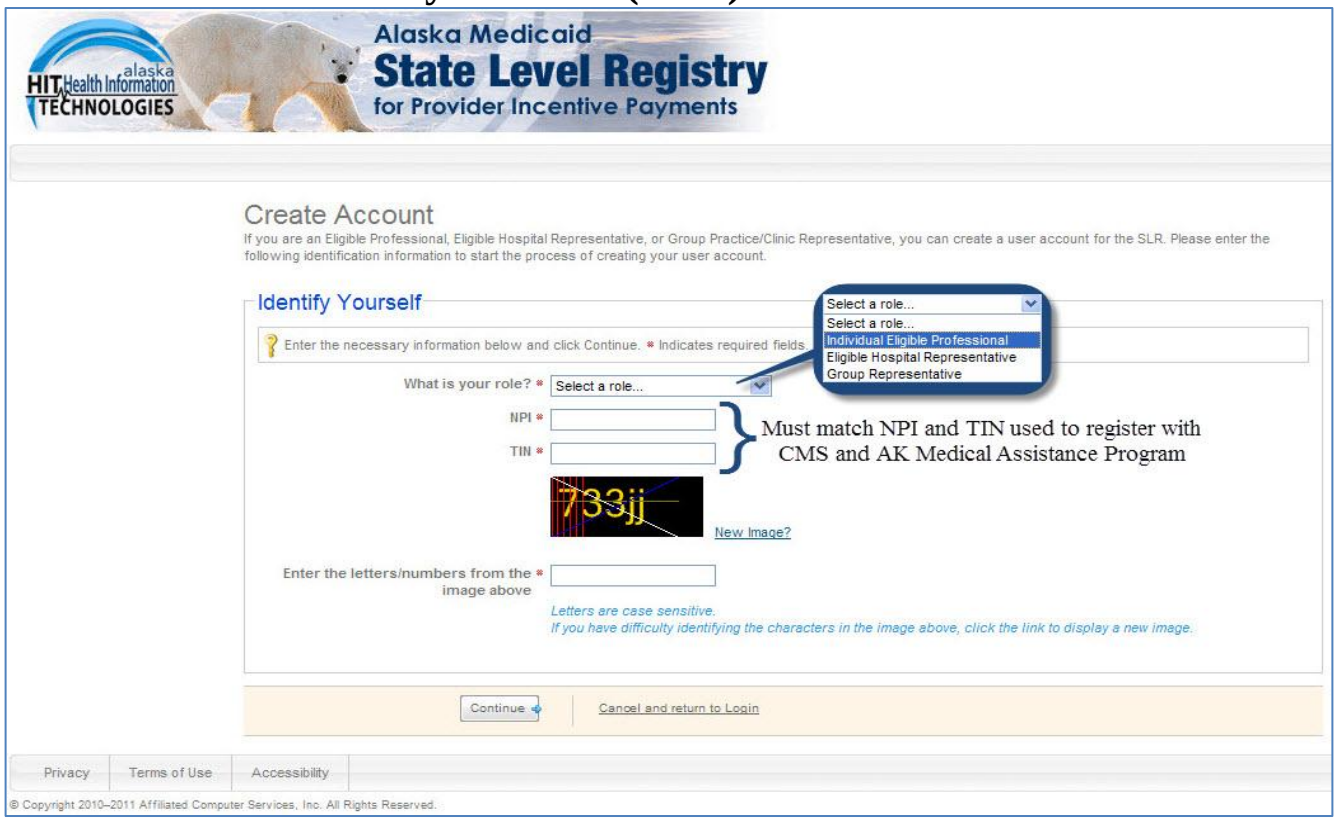


SLR Provider Outreach page-Step by Step Instructions (cont.)

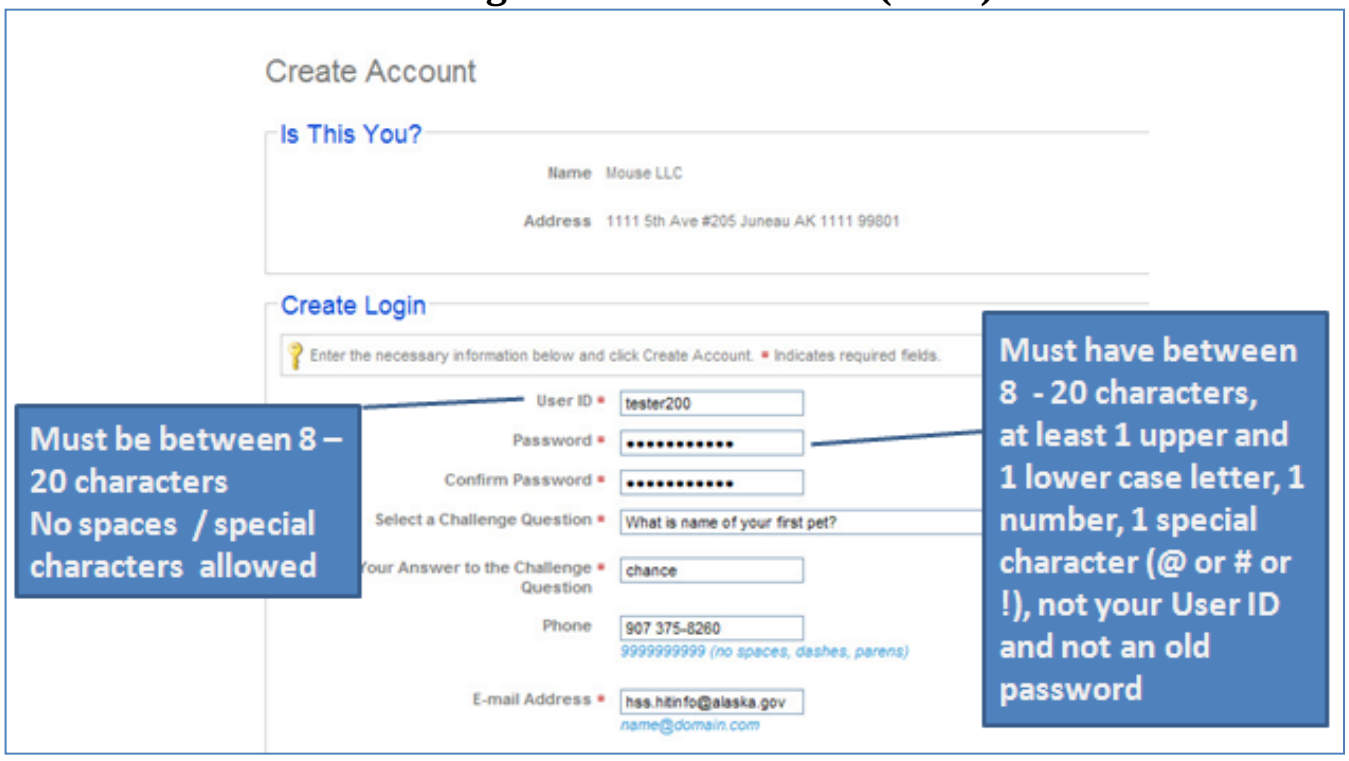


Create Account-SLR Registration

Create Account-Identify Yourself (cont.)



Create Account-Create Login ID and Password (cont.)

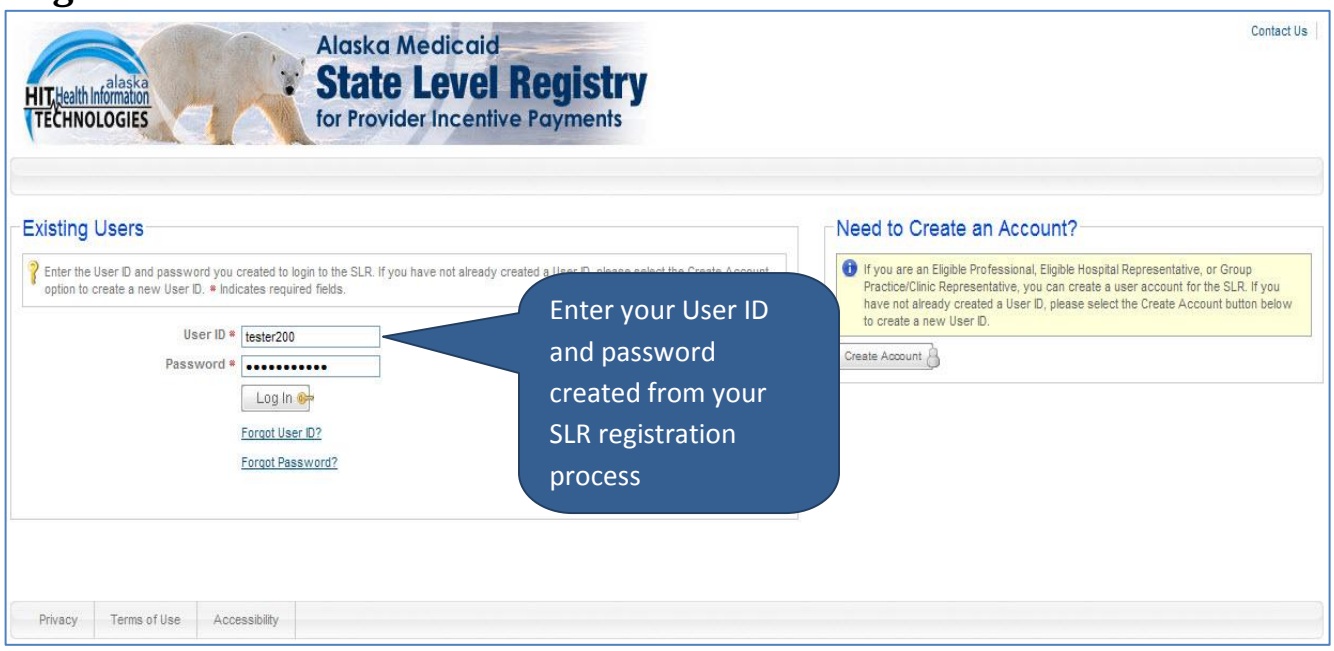


12 State Level Registry Provider Attestation

Eligible Professional and Hospital Provider SLR Attestation

The attestation is an amendment and becomes part of the to the provider's contract. Following are descriptions of the information that a provider will have to enter into the SLR and attest to upon completion of the application.

Login to the SLR

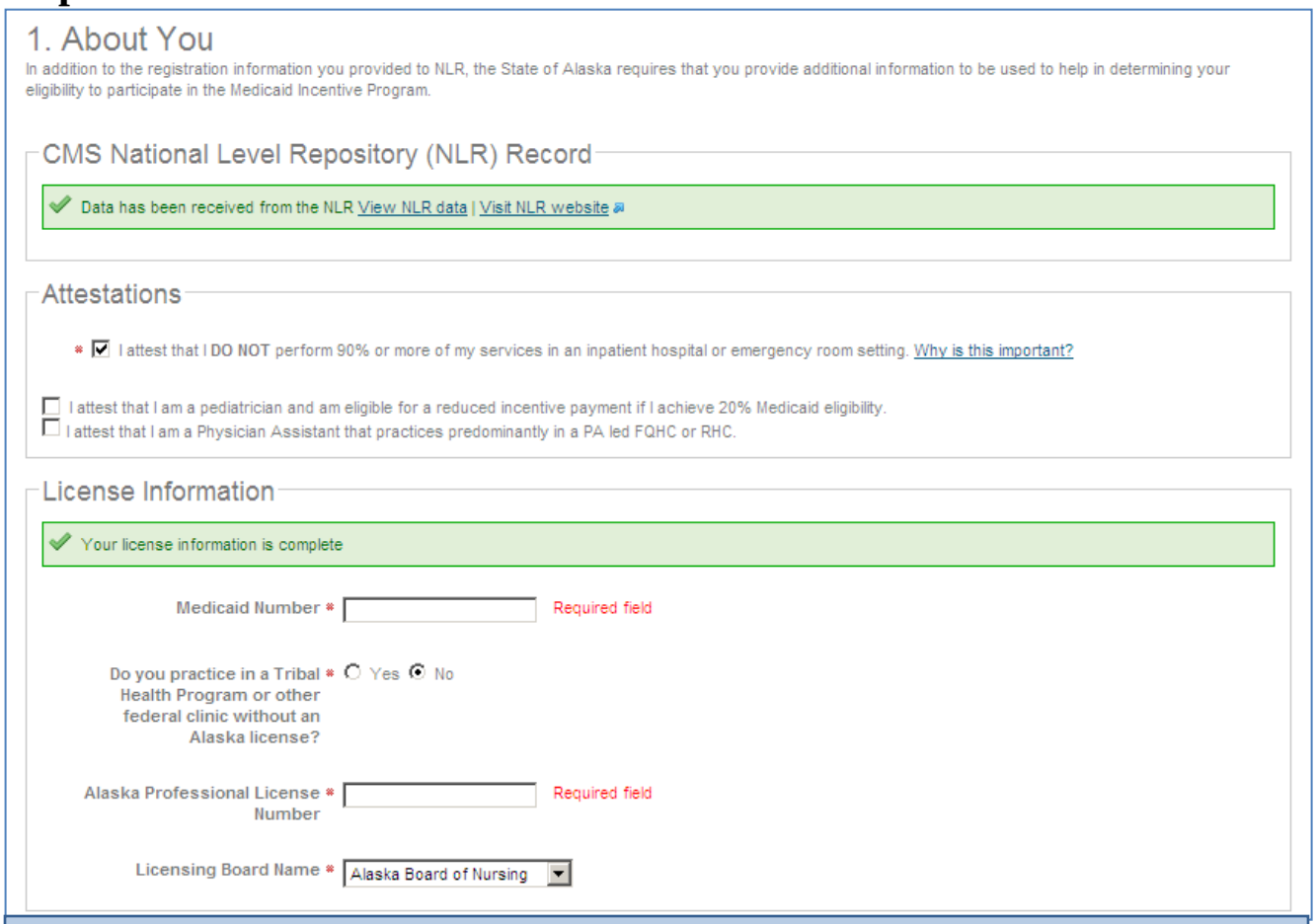


End User License Agreement and Terms of Use Agreement

SLR home page

The SLR home page is known as the Dashboard, which displays basic system and account management information, provider reports, and identifies the steps for attestation. On the Dashboard you can open the Help guide which provides detailed instructions on how to complete the SLR application.

Step 1-About You-EP



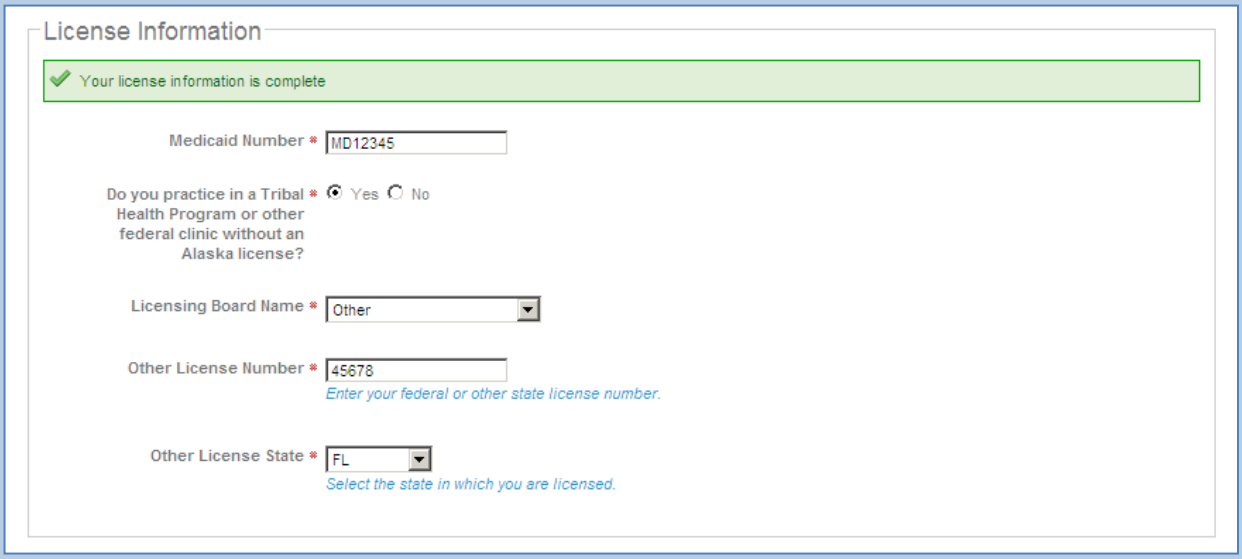
- **CMS National Level Repository (NLR) Record**- Identifies if your CMS registration data has been received.
- **Hospital based attestation**- Eligible professional may not be hospital based to qualify for the program. Eligible professionals are considered hospital based if 90% of more of their services are rendered in an inpatient or emergency room setting. If they are not hospital based, providers they must attest that they DO NOT perform 90% or more of their services in an inpatient hospital or emergency room setting.
- **Pediatrician attestation**-A pediatrician who is qualifying for the program at the minimum 20% Medicaid patient volume must attest that they are a pediatrician and are eligible to receive a reduced incentive payment amount if they achieve 20% Medicaid eligibility. Doctors who qualify as pediatricians may receive a reduced incentive payment if they achieve between 20%-29% Medicaid patient volume.
- **Physician Assistant attestation**-Physician assistants may only qualify for the Medicaid EHR Incentive Program if they practice in a FQHC or RHC that is led by a physician assistant, they must attest the they are a physician assistant that practices predominantly in a PA led FQHC or RHC.
- **License Information**-EPs must enter their Alaska Medicaid provider number, their Alaska professional license number and select the licensing board name. Eligible professionals must identify if they practice in an IHS clinic without an Alaska license.

Step 1-About You-EP (cont.)

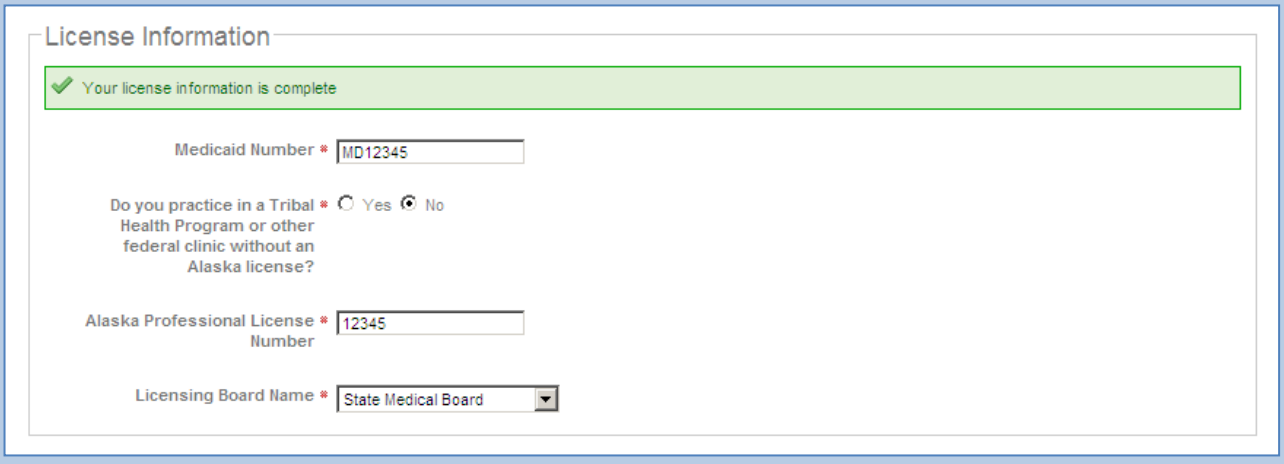
Practice in an IHS Clinic or Tribal Clinic

- **Practice in Indian Health Clinic**-EPs must identify if they practice in a Tribal clinic or other federal clinic without an Alaska license.
- **Other License Number and State**-If the EP practices in an IHS/Tribal clinic and does not have an Alaska professional license they must select the licensing board name and must enter the other professional license number and the state in which they were licensed in the Other License Number and Other License State data fields. If the provider is only licensed in Alaska then they must enter their Alaska Professional license number.

Licensed in another State

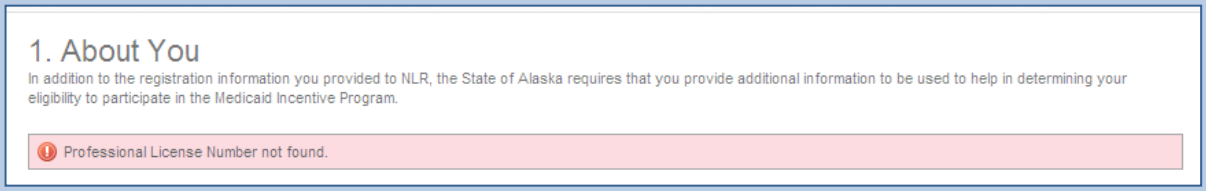


Alaska Professional License Number

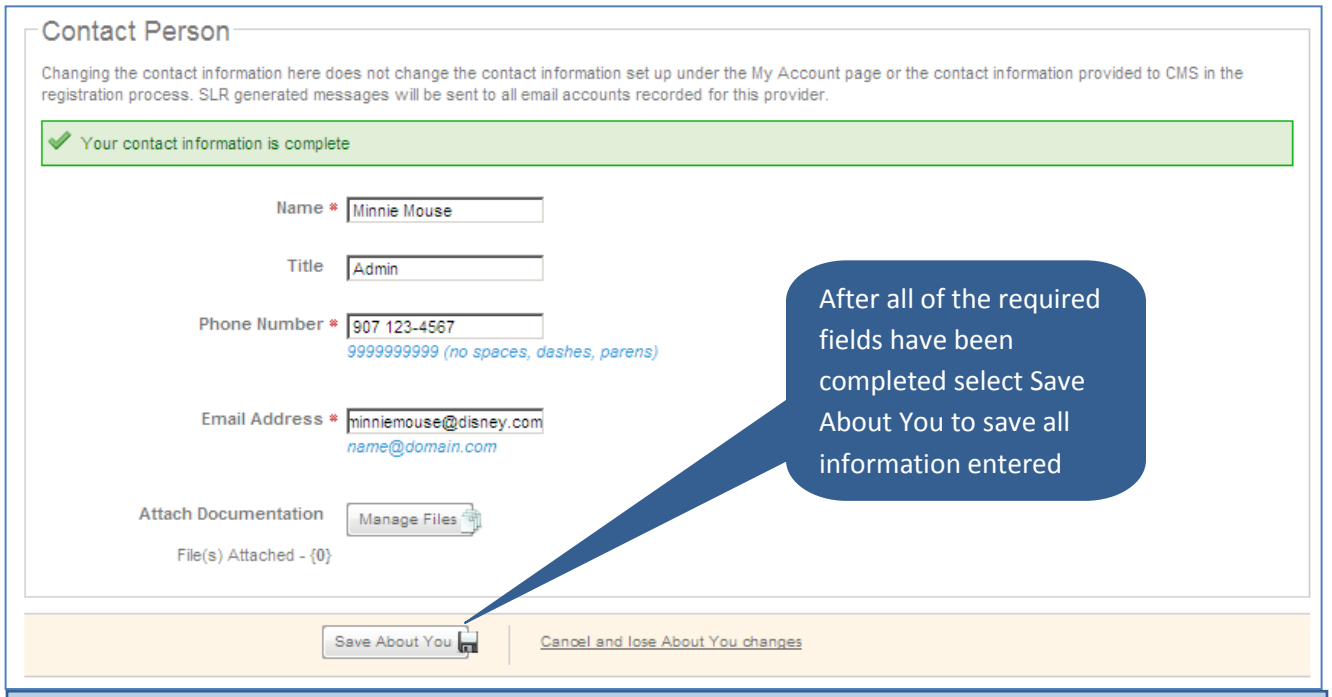


Step1-About You-License Information-EP (cont.)

Note: If you receive a message Professional License Number not found, you may still proceed to the next step of the application. Your professional license number will be validated at the payment approval process.

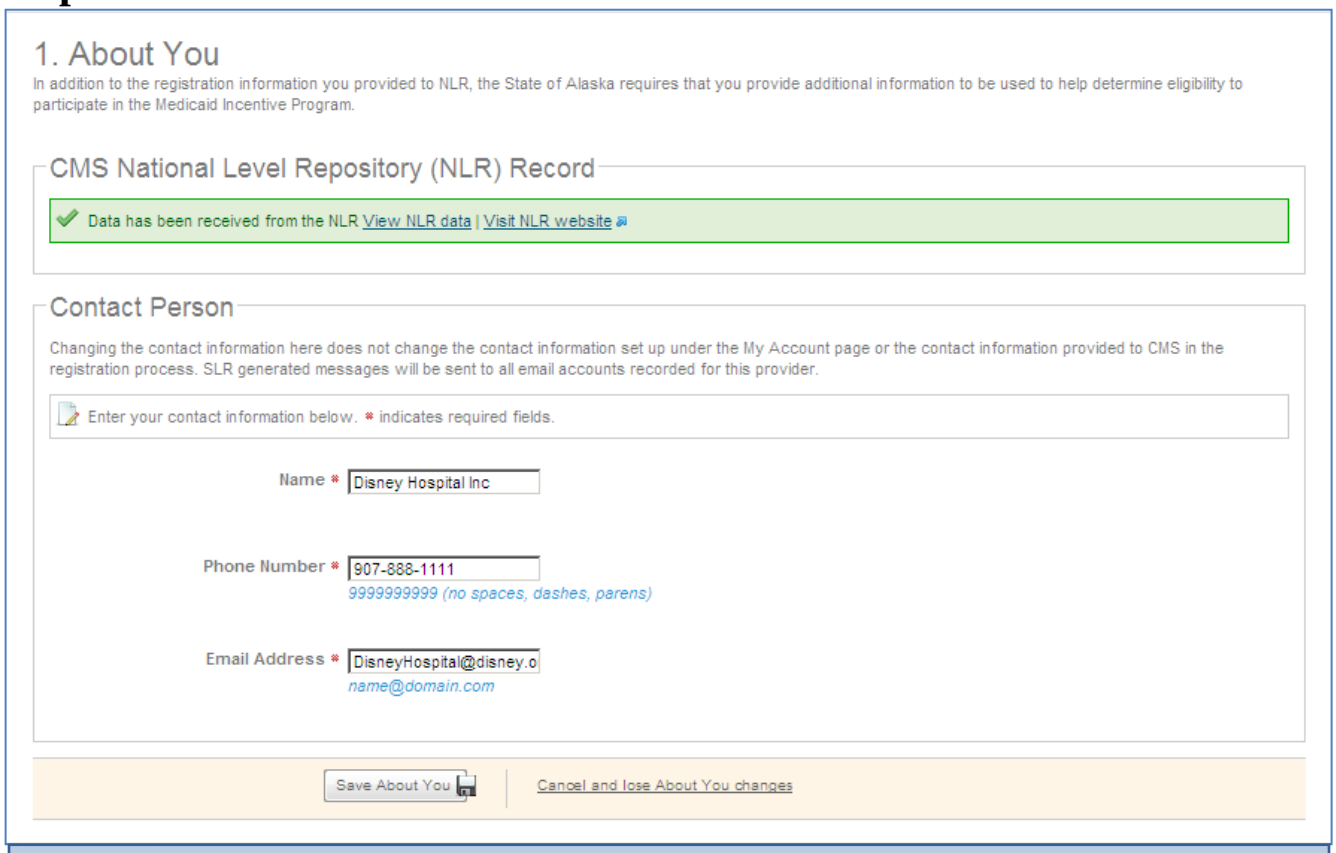


Step 1-About You-EP (cont.)



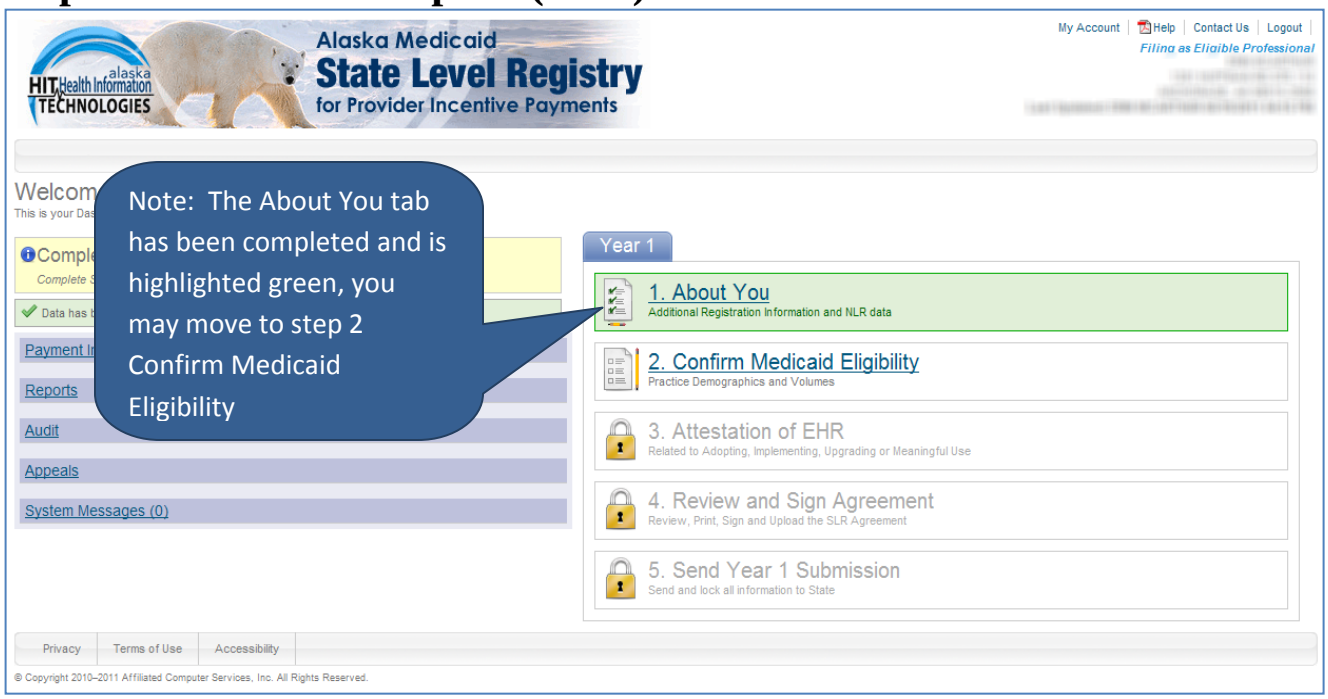
- **Contact Person**-EPs may identify another contact person name phone number and email address who may be contacted if there are any issues with your attestation in addition to the contact information set up under the My Account page.

Step 1-About You-EH

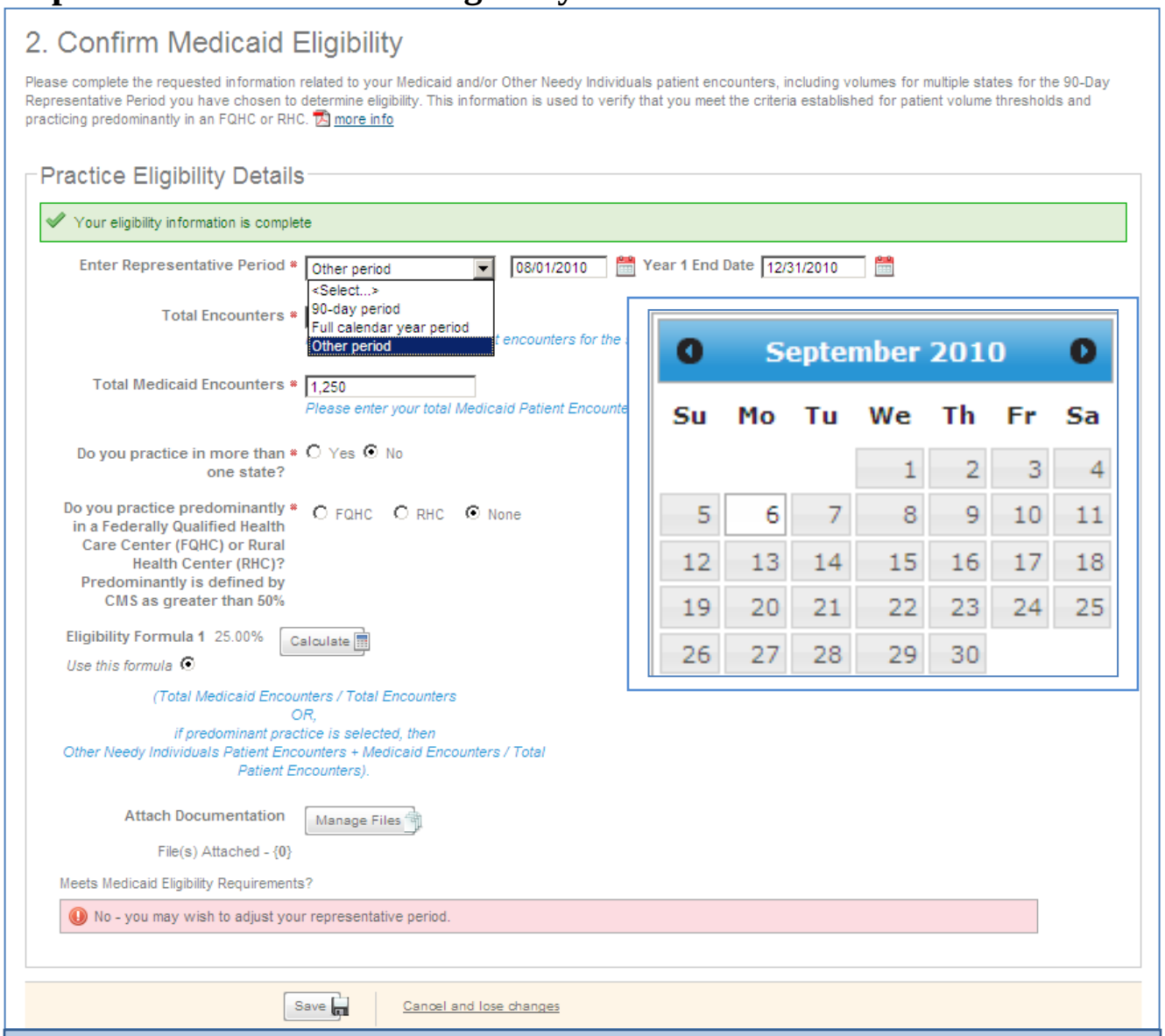


- **Contact Person**-EHs may identify another contact person name phone number and email address who may be contacted if there are any issues with your attestation in addition to the contact information set up under the My Account page.

Step 1-About You-Complete (cont.)

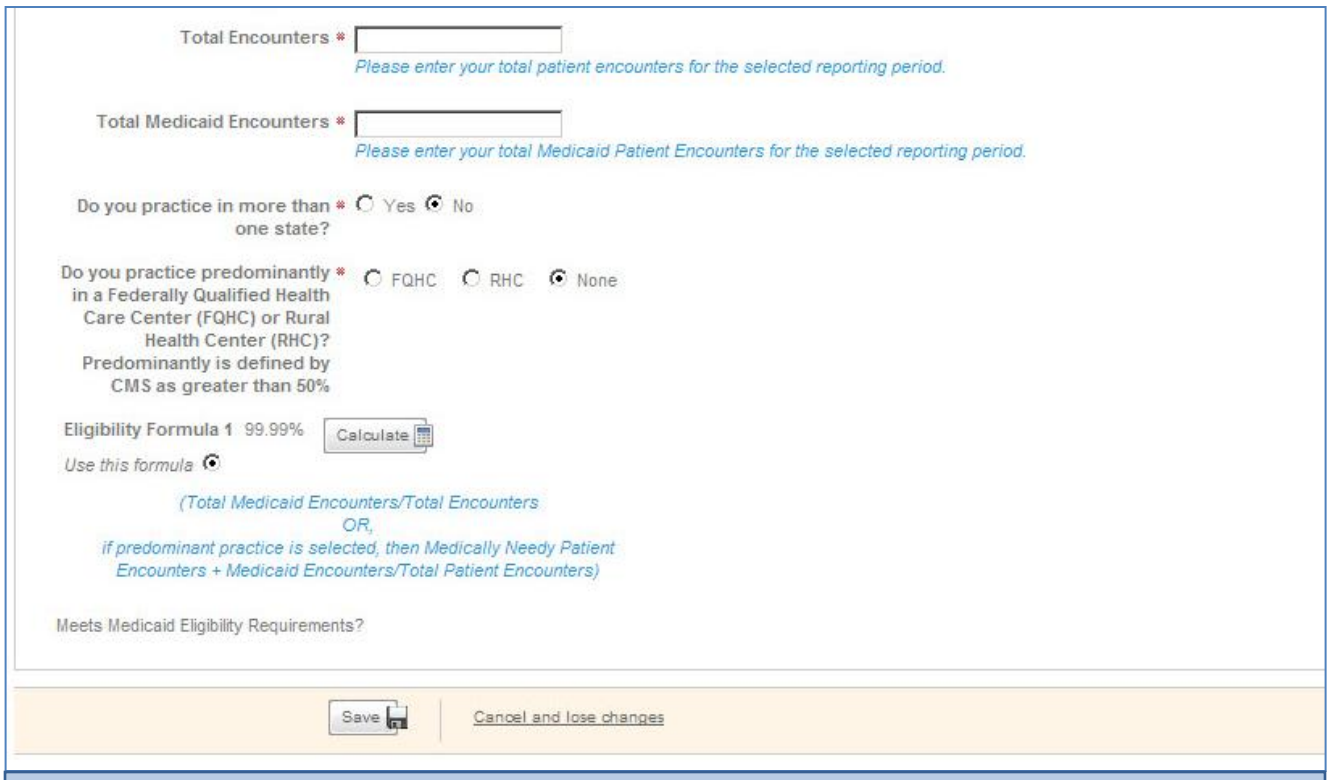


Step 2-Confirm Medicaid Eligibility-EP



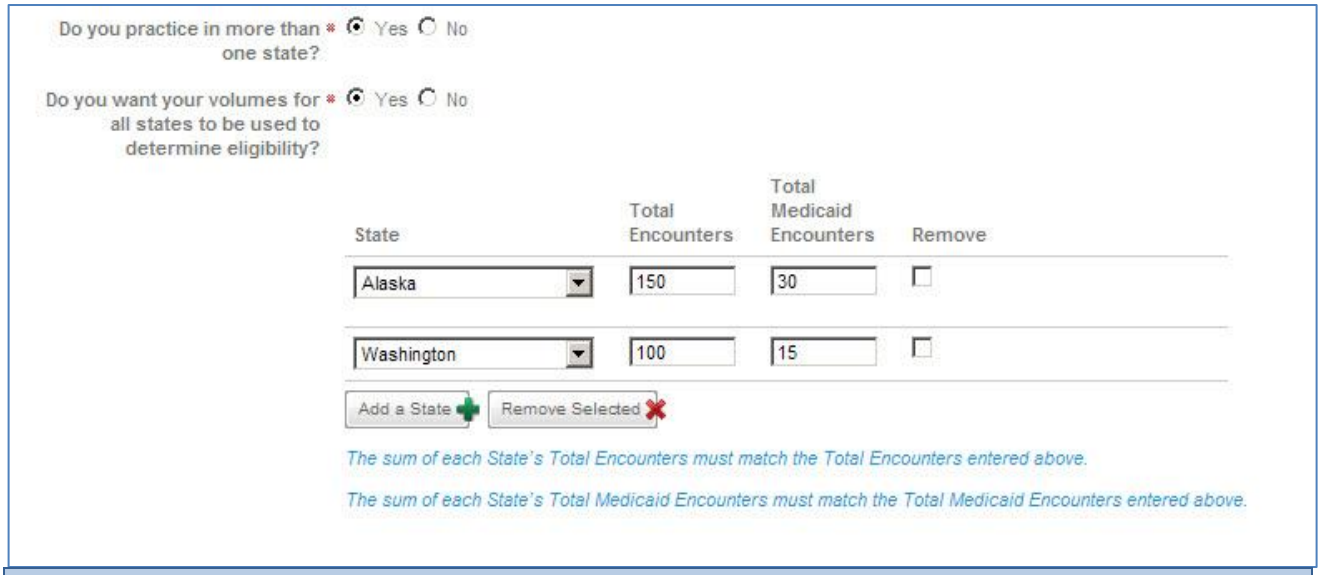
- **Enter the Start date of your 90-day or greater period**-The provider must select from the calendar the start date for the 90 days or greater representative period use to enter the patient volume data. The patient volume calculation must include a 90 day or greater selection period within the calendar year previous to the payment year.
- If you select a:
  - **90 day period** - you must select the start date of the selected 90 day period and the SLR will calculate the end date
  - **Full calendar year period** - you must enter the start date of January 1st of the previous calendar year and the SLR will calculate the end date
  - **Other period** - the period must be greater than 90 day and must be within the previous calendar year, you must select the start date and the end date of the greater than 90 day period

Step 2-Confirm Medicaid Eligibility-EP (cont.)



- **Total Encounters**- Enter the total number of encounters for the selected representative period.
- **Total Medicaid Encounters**- Enter the total number of Title XIX Medicaid encounters for the same representative period.
- **Do you practice in more than one state?** The eligible professional must identify if they practice in more than state. If the eligible professional does not practice in more than one state they may proceed to the next question. If the EP selects yes, they will have the option of using the Medicaid patient volume from the other state, although they are not required to use the out of state Medicaid patient volume.

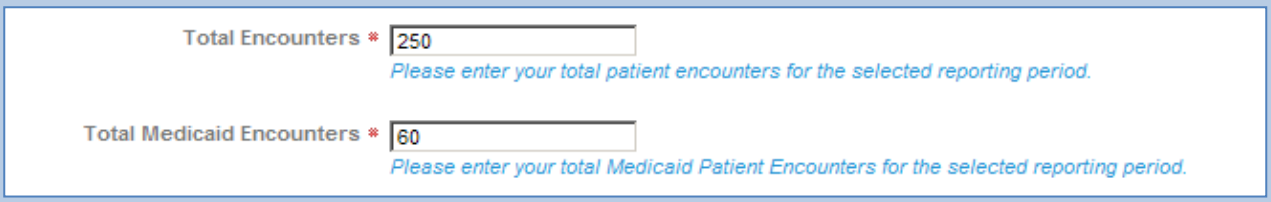
Step 2-Confirm Medicaid Eligibility-EP (cont.)



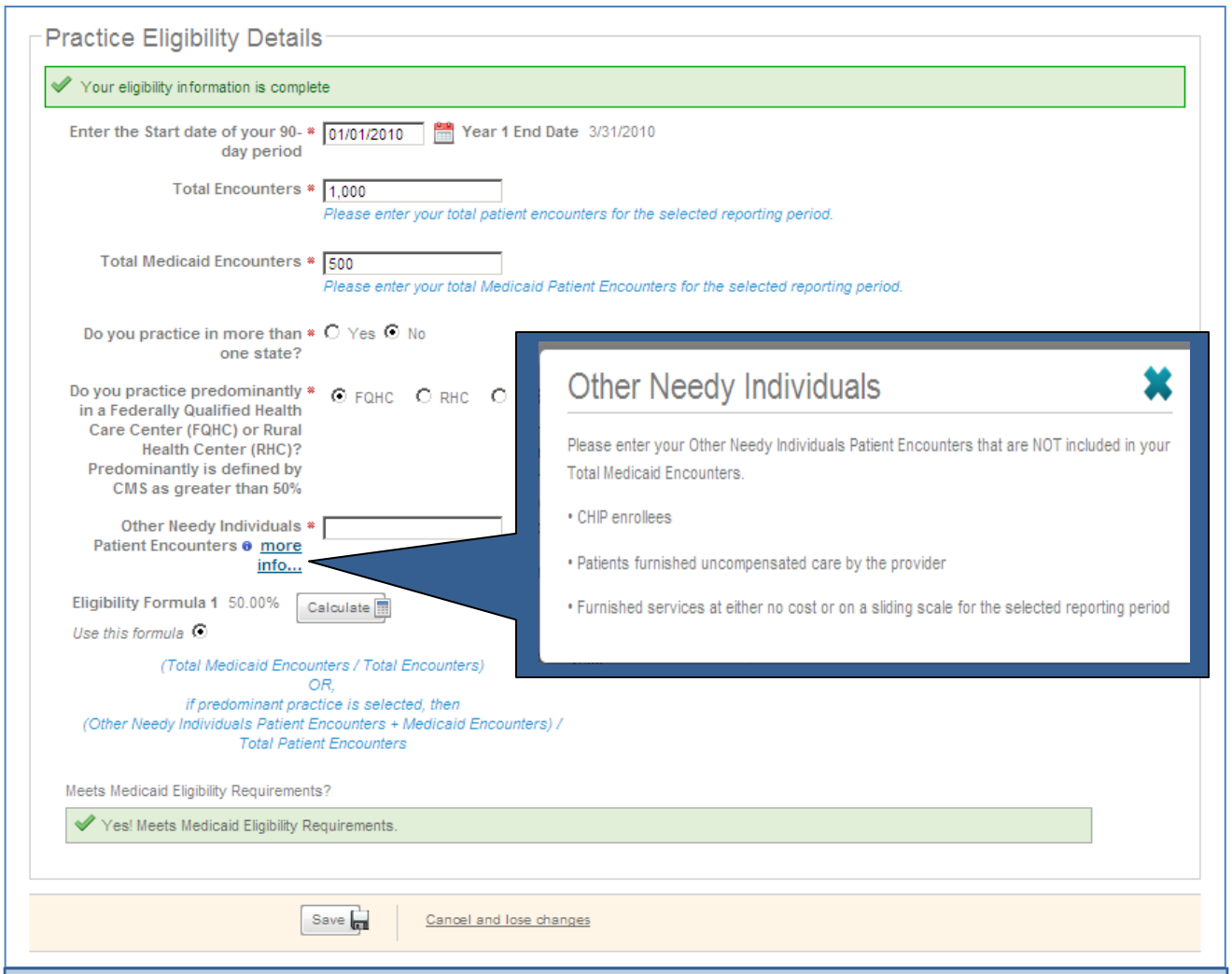
Other State Encounters

Do you want your volumes for all states to be used to determine eligibility?-If the EP identifies that they practices in more than one state they must identify if they want to use the Medicaid and total encounters from that state. If they select yes, they will be asked to enter the State, the total encounters from that state and the total Medicaid encounters for that state.

Note: If the EP uses the other states encounter volume they are required to enter the number of Medicaid encounters and total encounters for each of the states in which they practice, including Alaska, in these date fields. The total encounters and total Medicaid encounters entered in these fields must match the total encounters and total Medicaid encounters entered in the initial patient volume data entry.



Step 2-Confirm Medicaid Eligibility-EP (cont.)

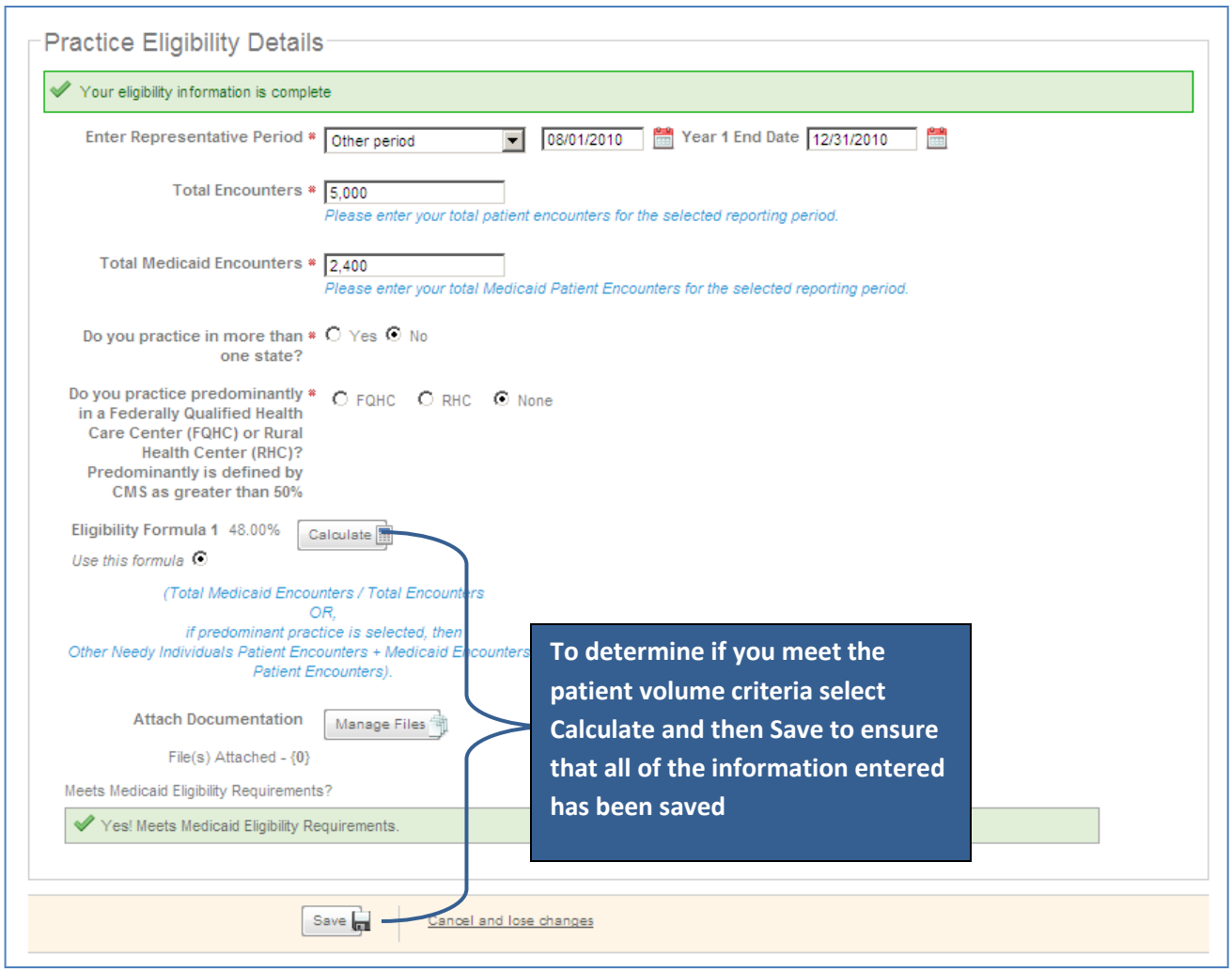


EP Practicing Predominantly in a FQHC or RHC

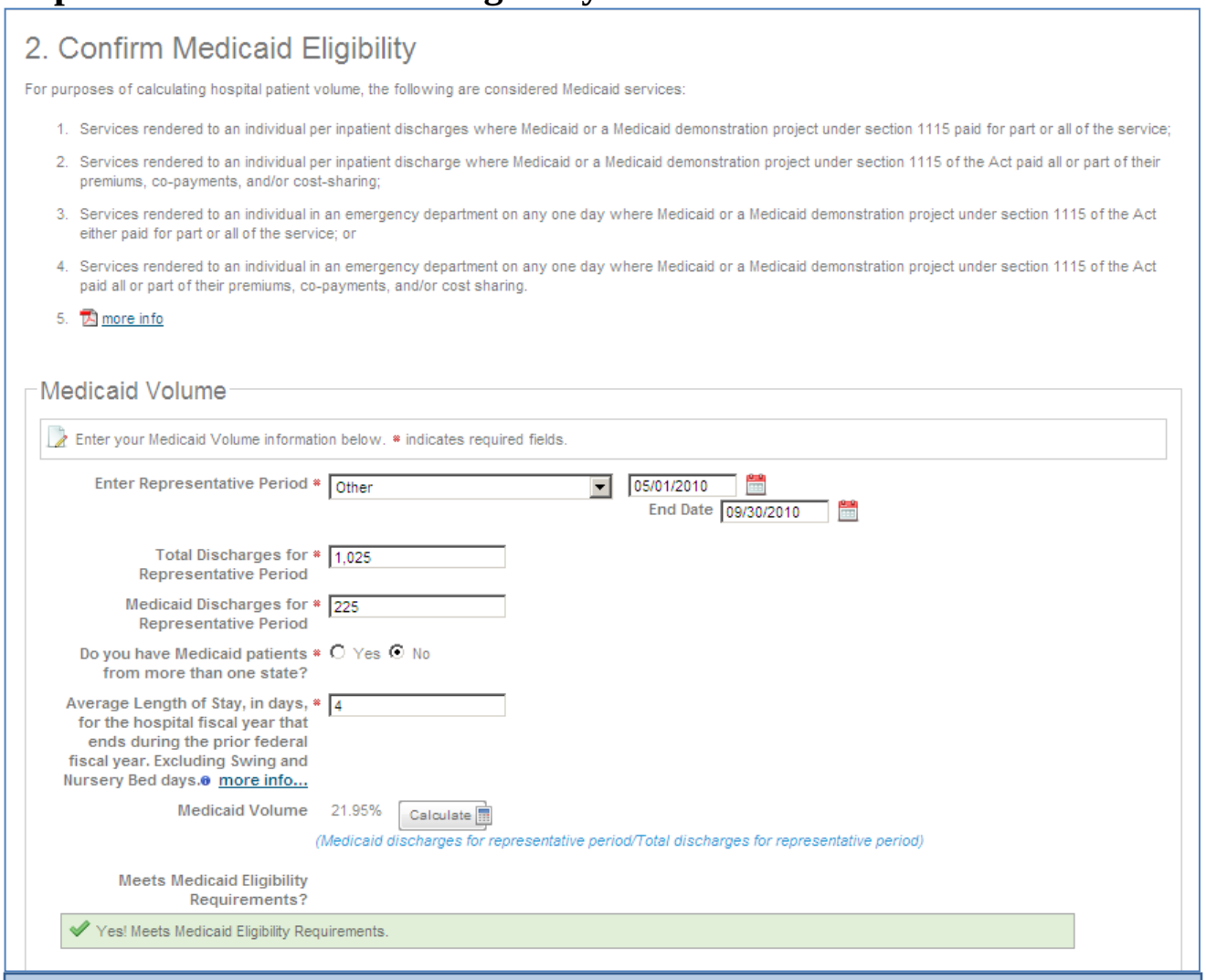
- **Needy Individual Patient Encounters**-Medicaid EPs practicing predominantly in a FQHC or RHC may use a needy individual patient volume. In the SLR the EP must enter the total number of needy individual encounters that are not included in the Total Medicaid Encounter volume entered in the initial patient volume data entry.

- **Practicing predominantly**- An EP practices predominantly in a FQHC or RHC when the clinical location is over 50% of the EPs total patient encounters over a 6 month time period.

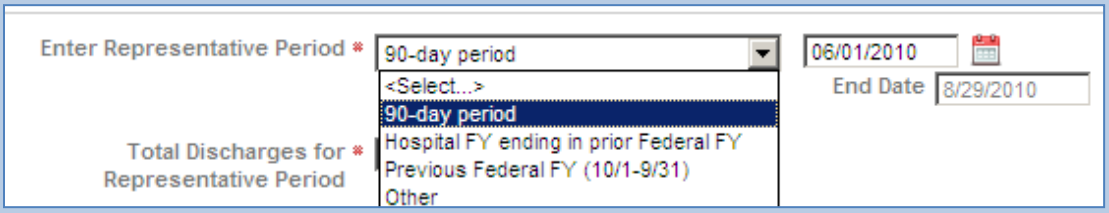
Step 2-Confirm Medicaid Eligibility EP-Complete (cont.)



Step 2-Confirm Medicaid Eligibility-EH

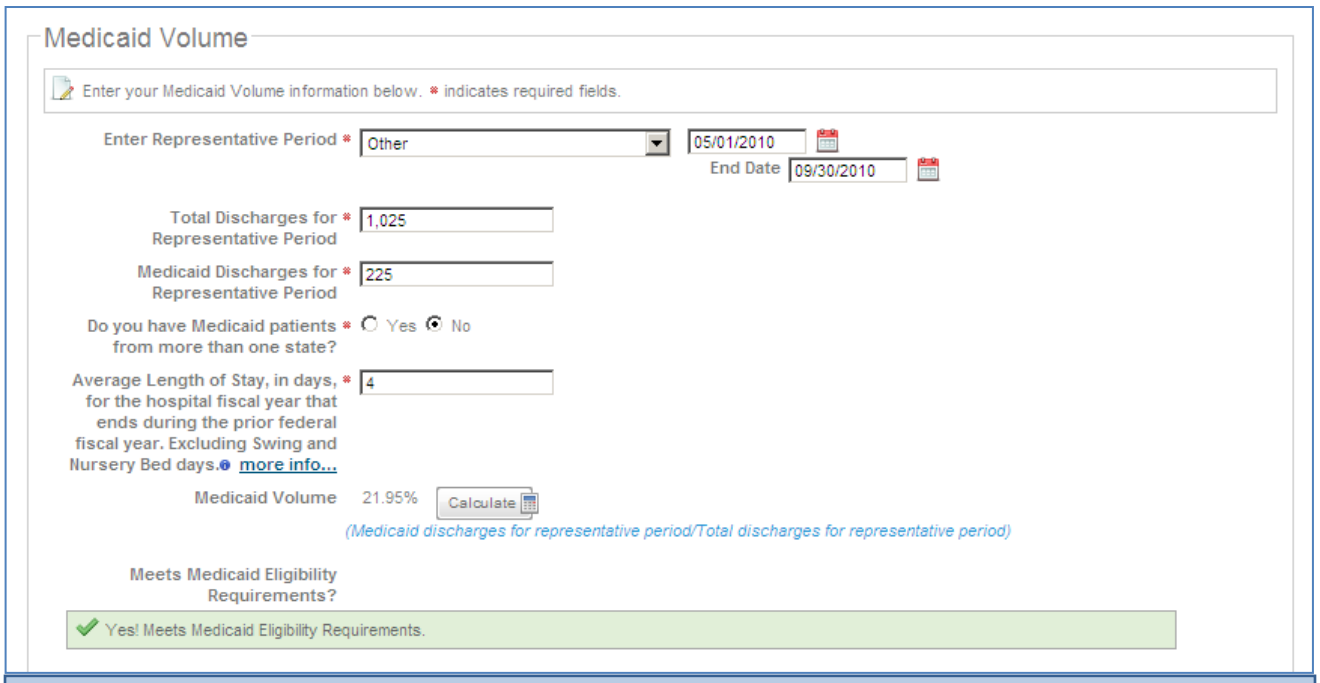


Enter Representative Period



- Select a 90 day or greater period to enter the hospital patient encounter information to establish the patient volume calculation.
- If the hospital selects a:
  - **90 day period**-you must select the start date of the selected 90 day period
  - **Hospital FY ending in the prior Federal FY**- you must enter the start date of the hospital fiscal year that end of the previous federal fiscal year of September 30th
  - **Previous Federal FY-** (10/1-09/30)
  - **Other period**-the period must be greater than 90 day and must be within the previous federal fiscal year

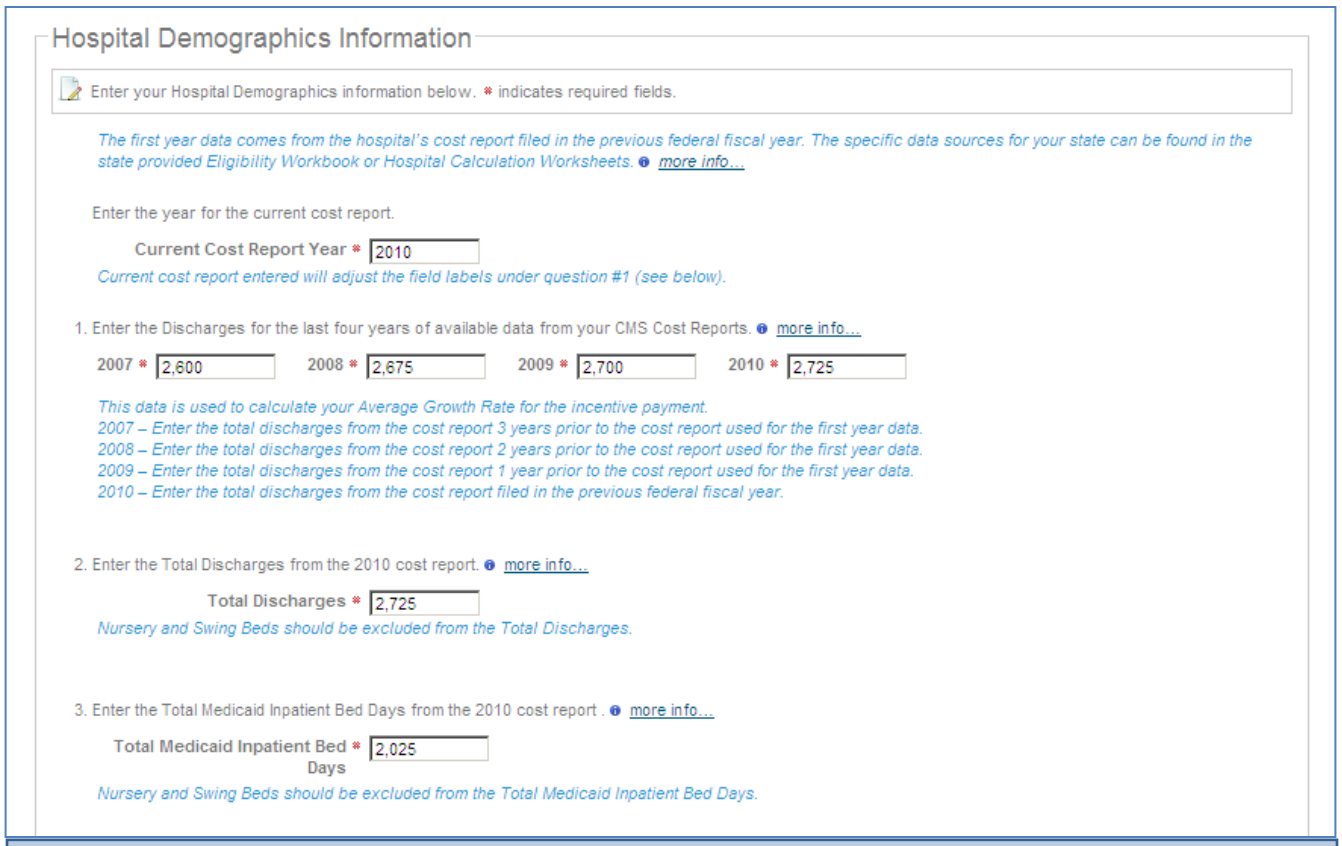
Step 2-Confirm Medicaid Eligibility-EH (cont.)



Medicaid Volume

- **Total Discharges for Representative period**-Enter the Total discharges over the selected representative period
- **Medicaid Discharges for Representative period**-Enter the Medicaid inpatient discharges and emergency room discharges over the selected representative period
- **Medicaid patients from another state**-Identify if the hospital has Medicaid patients outside the state of Alaska
- **Average Length of Stay**-Enter the average length of stay for the hospital fiscal year that ends in the prior federal fiscal year, the average length of stay calculation is calculated by the Total inpatient bed days divided by Total Discharges
- **Medicaid Volume Calculation**- Select the calculate button to determine if the hospital meets the minimum patient volume

Step 2-Confirm Medicaid Eligibility-EH (cont.)



Hospital Demographic Information

Current Cost Report Year-Enter the year from the hospital cost report that has ended in the previous federal fiscal year

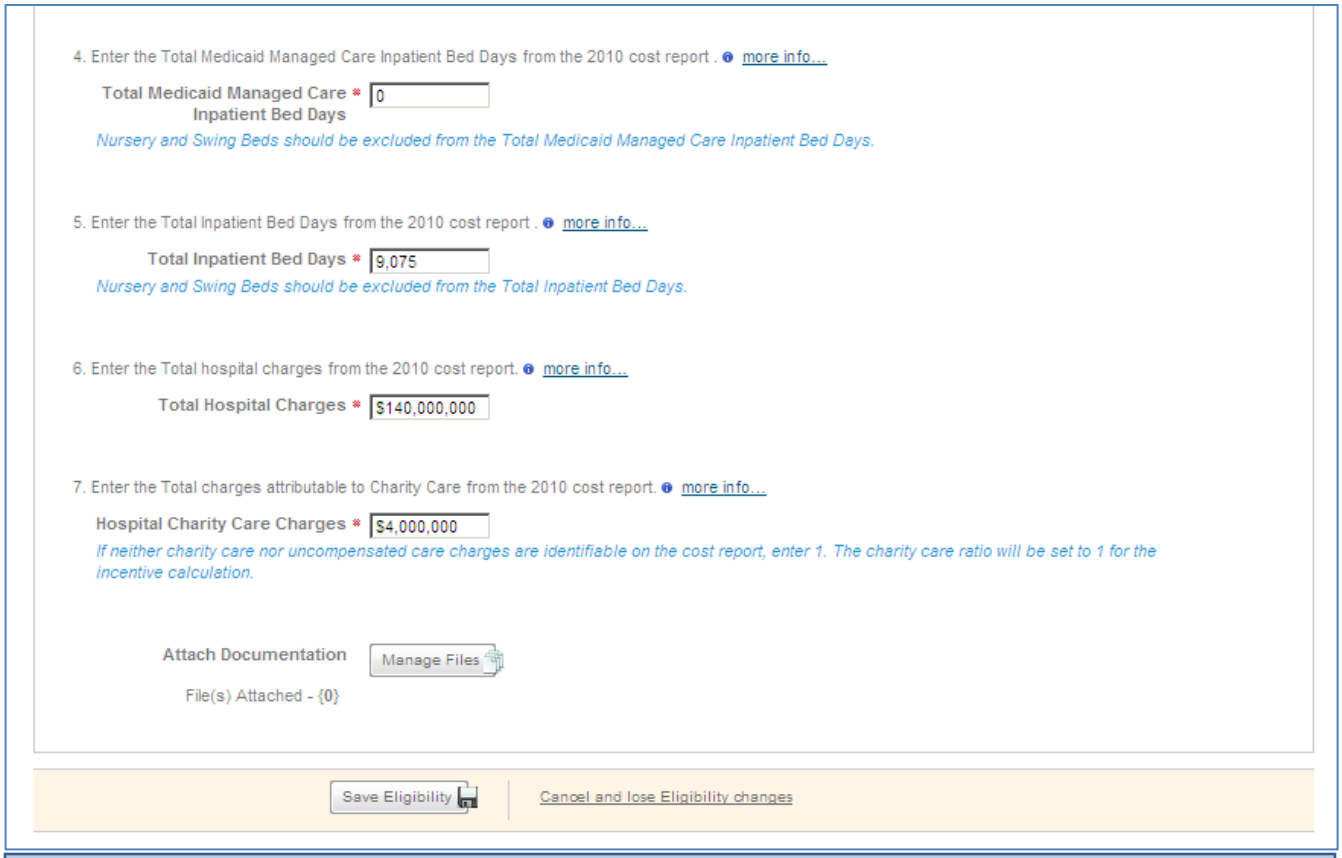
4 years of Discharge data-Enter the total discharges for the acute care portion of the hospital, this excludes nursery discharges, for the previous 4 most recent years of hospital cost report discharge data.

Total Discharges-Enter the total discharges for the acute care portion of the hospital from the hospital cost report ending in the federal fiscal prior to the payment year. The discharges also exclude nursery discharges. Note: Payments years are based on the federal fiscal year for hospitals.

Example: If a hospital is applying for an incentive payment in federal fiscal year 2011 (October 1, 2010-September 30, 2011), and the hospital fiscal year runs from July1-June 30, the hospital cost report data used would be collected from the hospital cost report ending on June 30, 2010.

Total Medicaid Inpatient Bed Days-Enter the total Medicaid Inpatient Bed days from the hospital cost report ending in the federal fiscal year prior to the payment year. The Medicaid inpatient bed days exclude nursery days. If a patient is dually eligible for both Medicare and Medicaid, if the Medicare inpatient bed days would count for the purposes of calculating the Medicare share they cannot be counted in the numerator for the Medicaid share.

Step 2-Confirm Medicaid Eligibility-EH (cont.)



Hospital Demographic Information

Medicaid Managed Care Inpatient Bed Days-The Alaska Medical Assistance Program does not have a Medicaid Managed Care program. Hospitals may enter "0" in this field in the SLR.

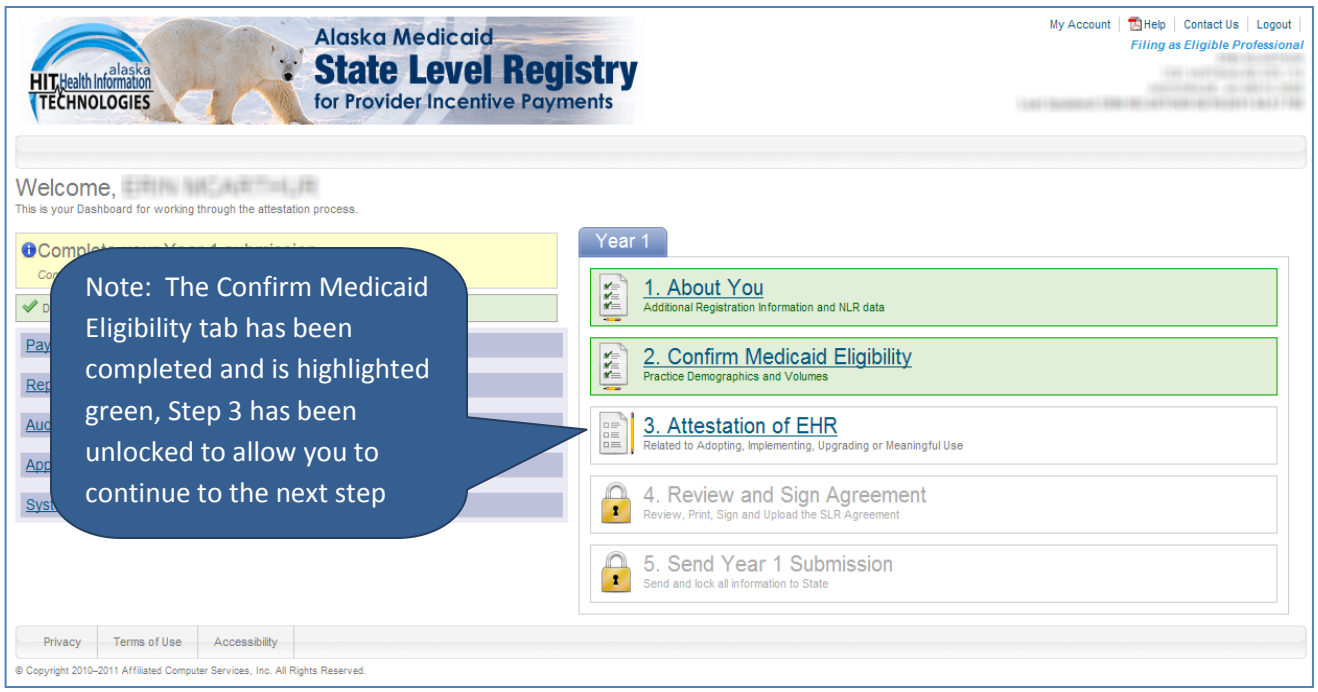
Total Inpatient Bed Day- Enter the total inpatient bed days for the acute care portion of the hospital from the hospital cost report ending in the federal fiscal prior to the payment year. The inpatient bed days excludes nursery days.

Total Hospital Charges-Enter the total hospital charges from the hospital cost report ending in the federal fiscal year prior to the payment year.

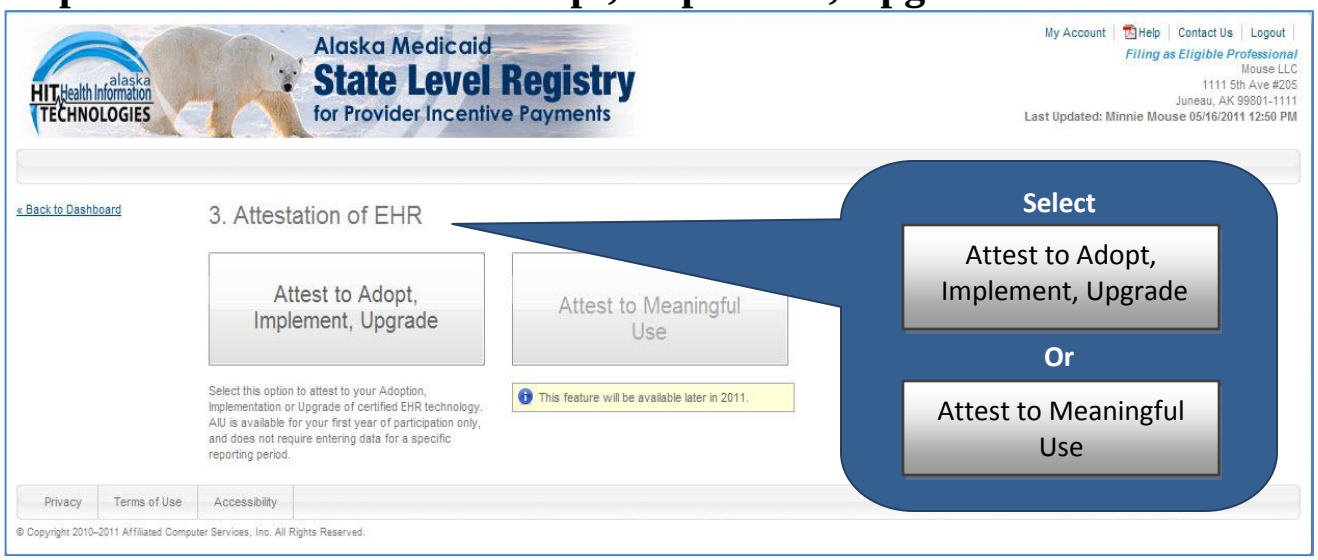
Hospital Charity Care Charges-Enter the total hospital charity care charges from the hospital cost report ending in the federal fiscal year prior to the payment year.

Save Eligibility-Once all of the information has been entered select save eligibility and you will be taken to the next screen Step 3. Attestation of EHR

SLR Home page-Confirm Medicaid Eligibility-Complete



Step 3-Attestation of EHR-Adopt, Implement, Upgrade

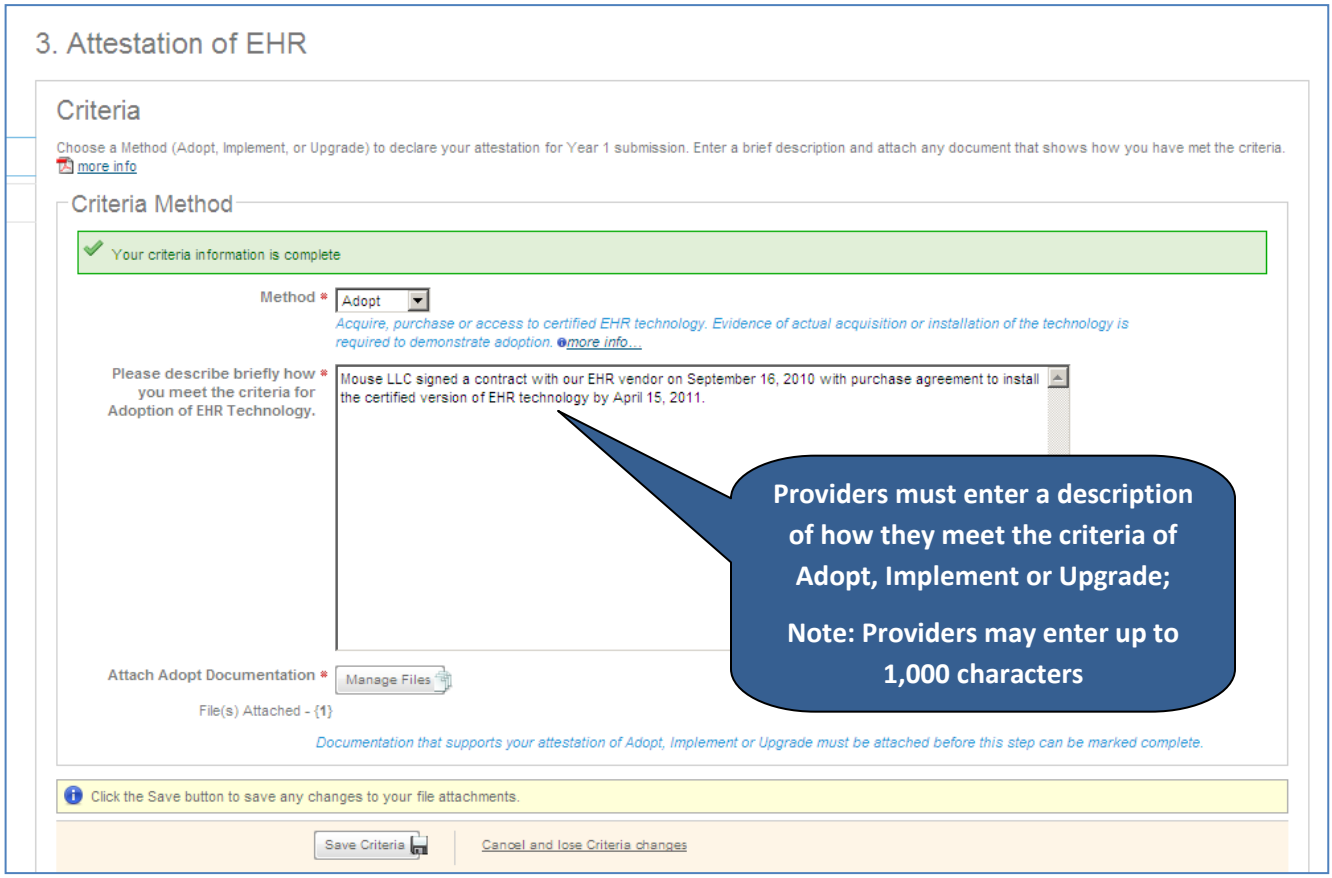


Attestation of EHR- In the first year of participation in the Medicaid EHR Incentive Program eligible professionals and eligible hospitals have the option to attest to Adopt, Implement or Upgrade to a certified EHR Technology or to meaningful use. In the second year of participation they may attest to meaningful use.

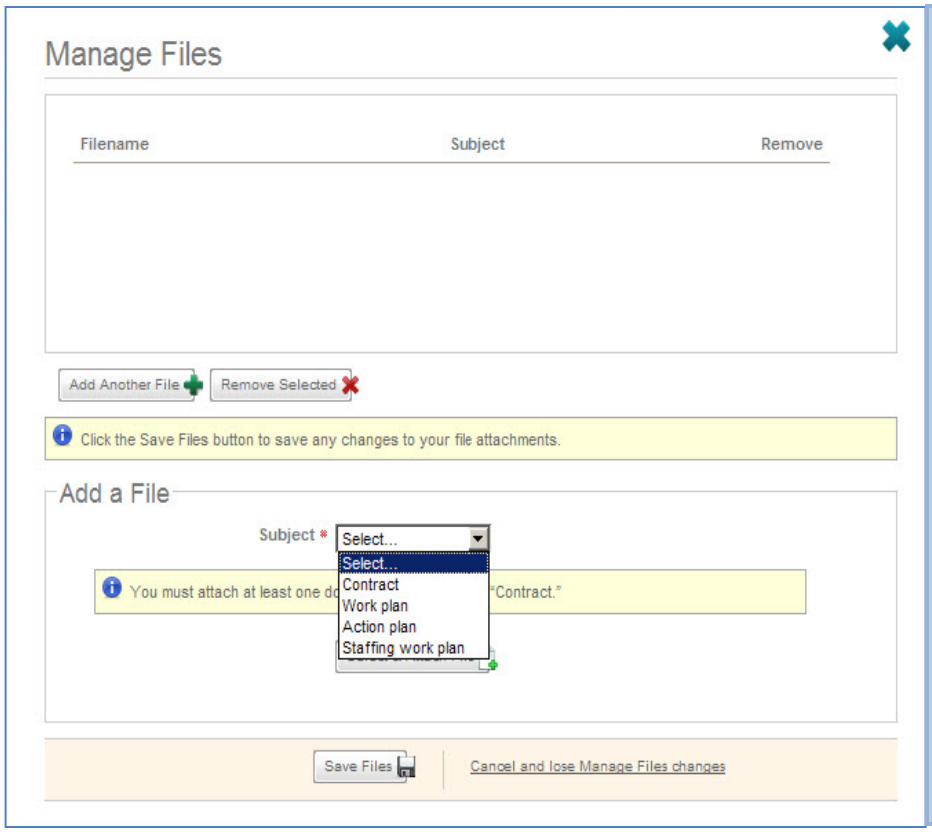
Note: The attestation of meaningful use will be available for the Alaska Medicaid EHR Incentive Program in the beginning of 2012.

Step 3-Attestation of EHR-AIU Method

Step 3-Attestation of EHR-AIU Method (cont.)



Step 3-Attestation of EHR-AIU Method-Attach Document (cont.)

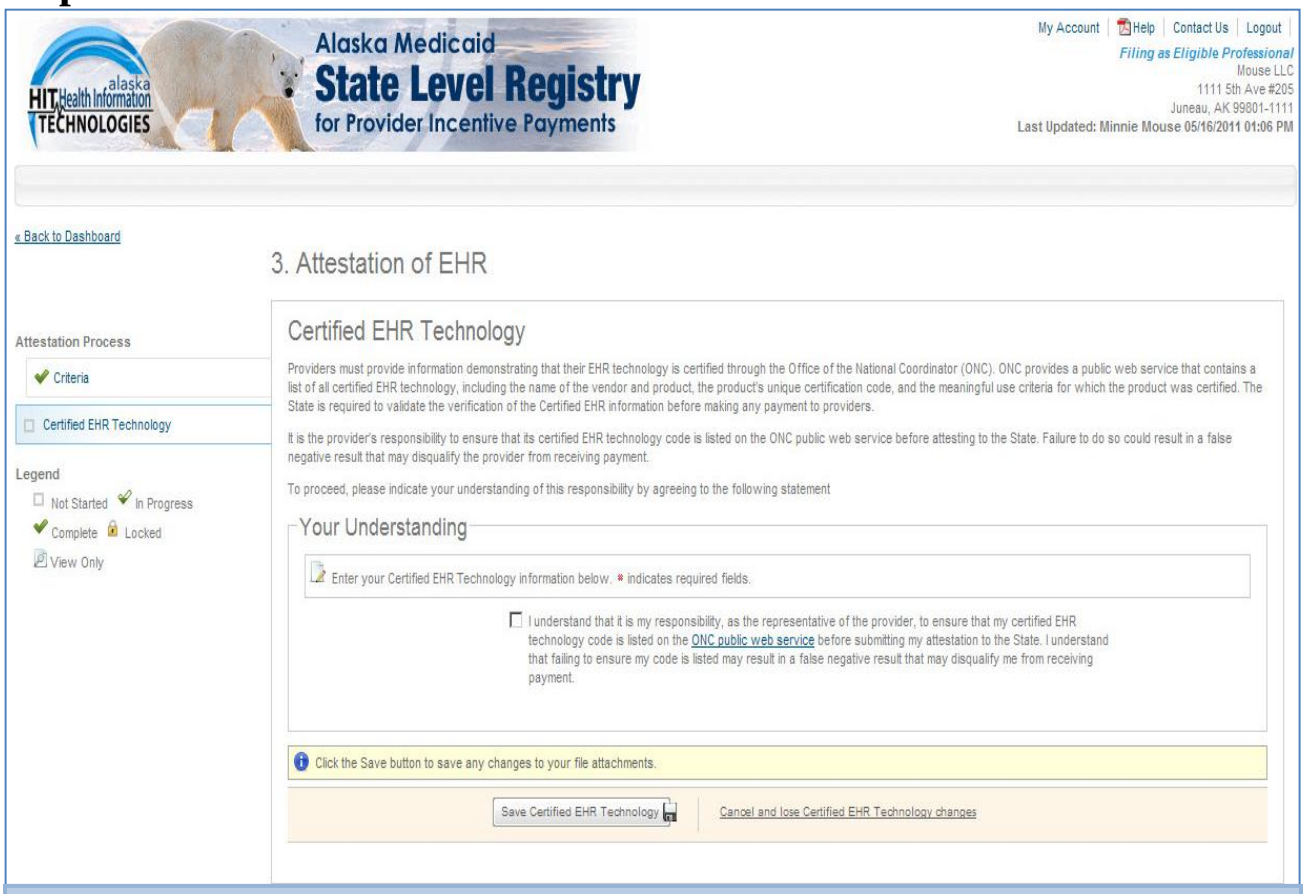


Manage Files

Providers must upload a file that supports the criteria for Adopt, Implement or Upgrade. At a minimum, providers are required to upload a document with a subject of "Contract" in order to complete the SLR attestation process. Other acceptable documents could include a work plan, action plan or staffing work plan.

Note: A letter of agreement that has been signed by both the provider/group and the EHR vendor is an acceptable document to upload under "Contract"

Step 3-Attestation of EHR-EHR Certification

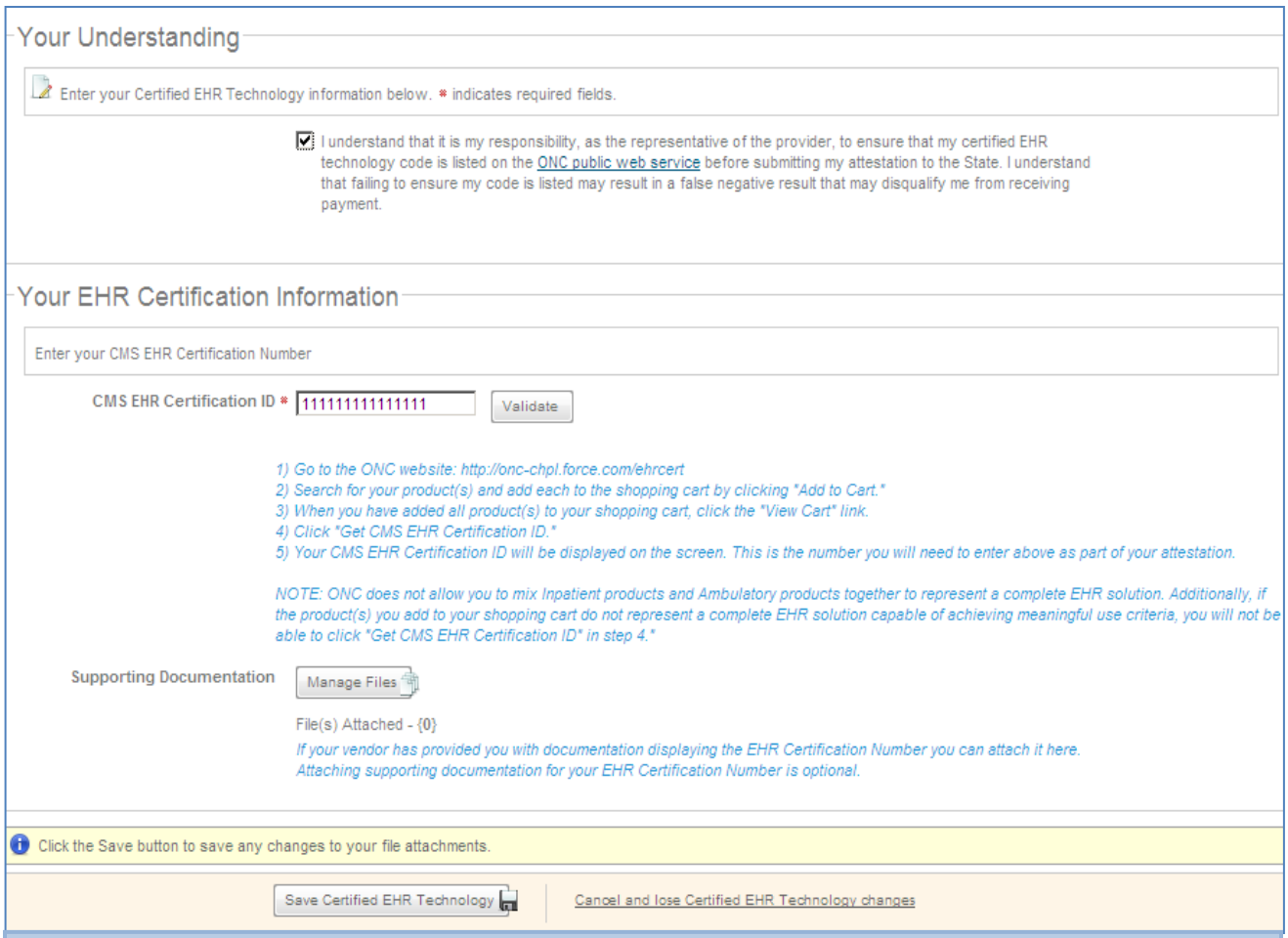


Your Understanding-The provider or representative of the provider must agree to the following statement:

☑ I understand that it is my responsibility, as the representative of the provider, to ensure that my certified EHR technology code is listed on the ONC public web service before submitting my attestation to the State. I understand that failing to ensure my code is listed may result in a false negative result that may disqualify me from receiving payment.

Once you agree with the "Your Understanding" statement, additional steps will appear where you will be required to enter the EHR Certification Information

Step 3-Attestation of EHR - EHR Certification (cont.)



CMS EHR Certification ID-You must enter the CMS EHR Certification ID

1) Go to the ONC website: http://onc-chpl.force.com/ehrcert
2) Search for your product(s) and add each to the shopping cart by clicking "Add to Cart."
3) When you have added all product(s) to your shopping cart, click the "View Cart" link.
4) Click "Get CMS EHR Certification ID."
5) Your CMS EHR Certification ID will be displayed on the screen. This is the number you will need to enter above as part of your attestation.

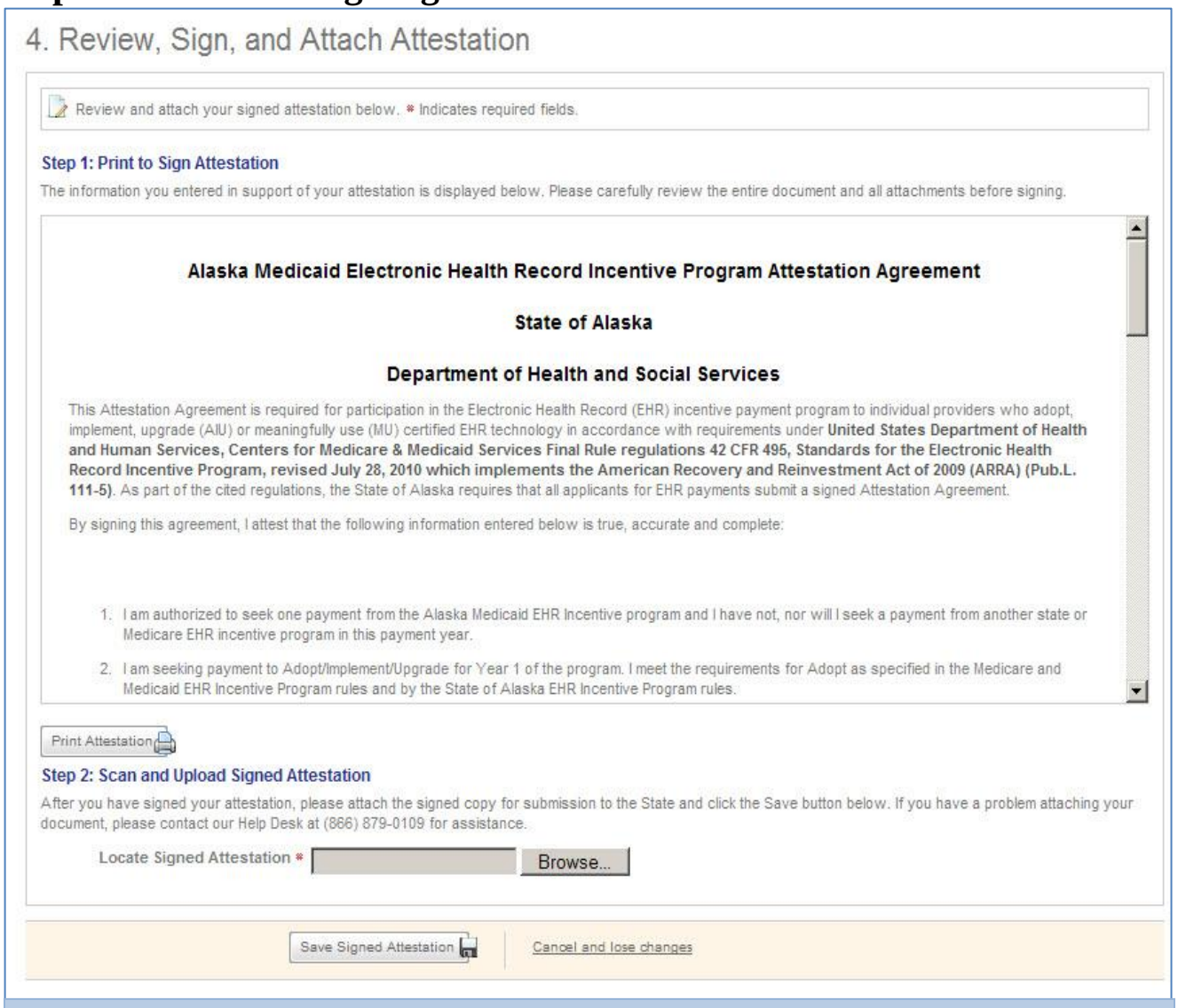
Ex. Your CMS EHR Certification ID is: 3000000MCAID4AK

Note: ONC does not allow you to mix Inpatient products and Ambulatory products together to represent a complete EHR solution. Additionally, if the product(s) you add to your shopping cart do not represent a complete EHR solution capable of achieving meaningful use criteria, you will not be able to click "Get CMS EHR Certification ID" in step 4."

Supporting Documentation-If your vendor has provided you with documentation displaying the EHR Certification Number the document may be attached here. Attaching the additional supporting documentation for your EHR Certification number is optional.

SLR Home page-Attestation of EHR-Complete

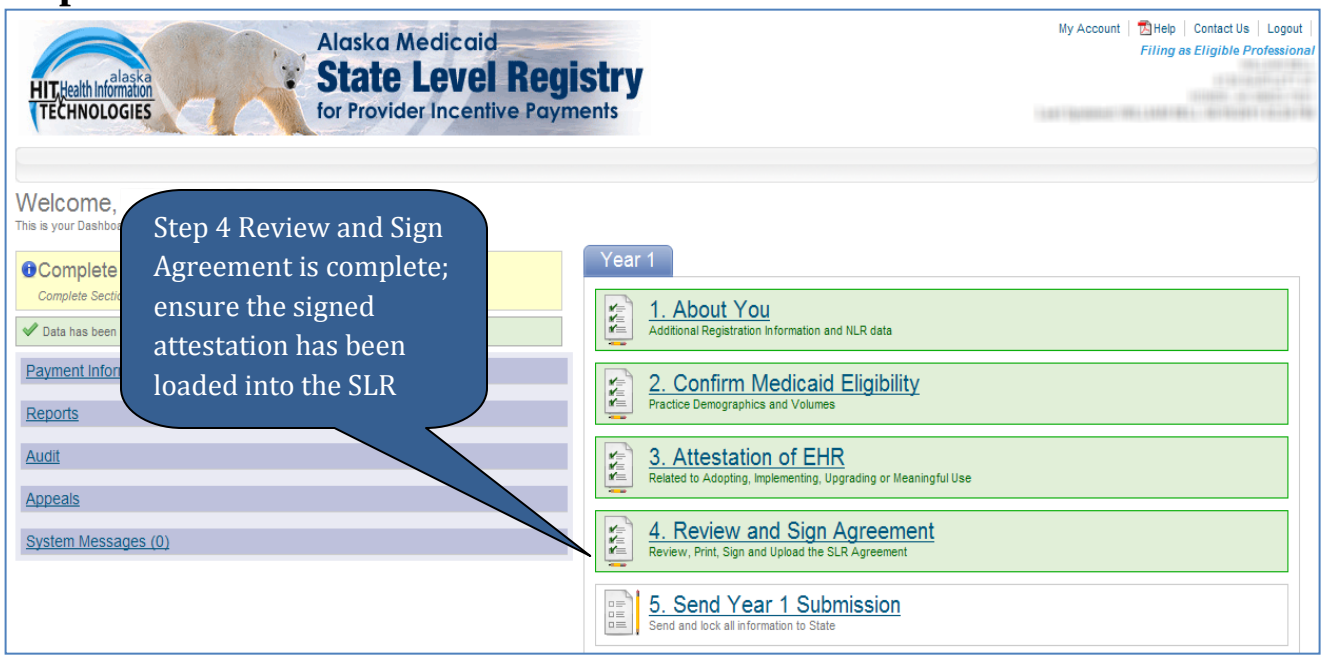
Step 4-Review and Sign Agreement



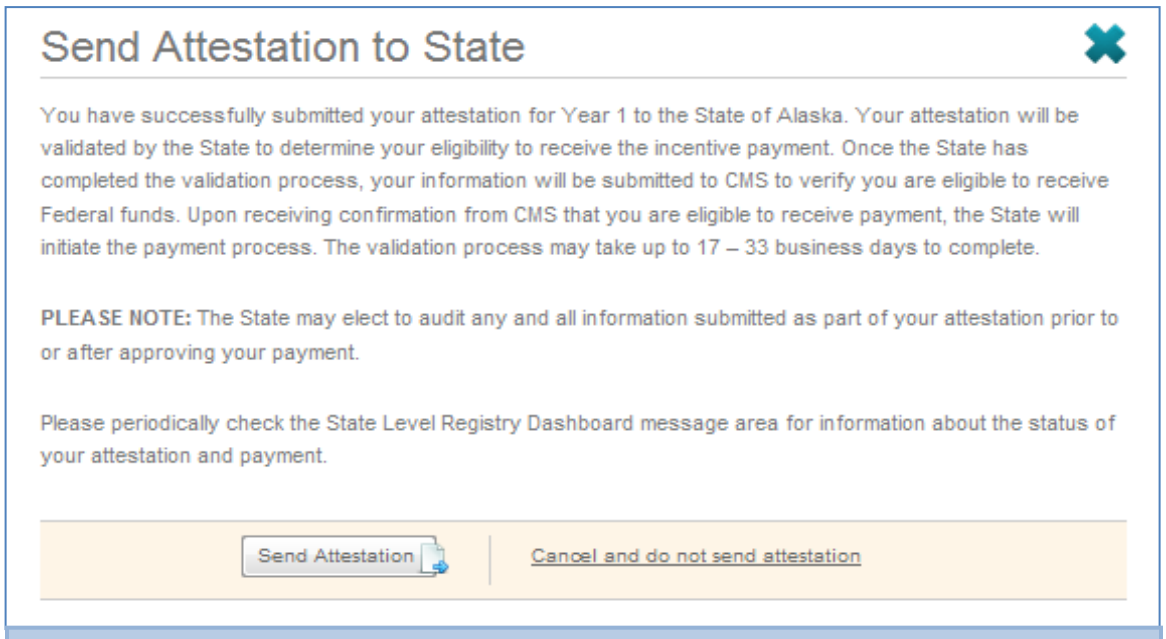
Review, Sign and Attach Attestation

- After reviewing and printing the completed attestation agreement you must sign the attestation and upload the signed agreement into the SLR
    - To upload the signed attestation agreement click Browse and select the saved agreement and click Save Signed Attestation to save the agreement in the SLR

Step 5-Send Year 1 Submission



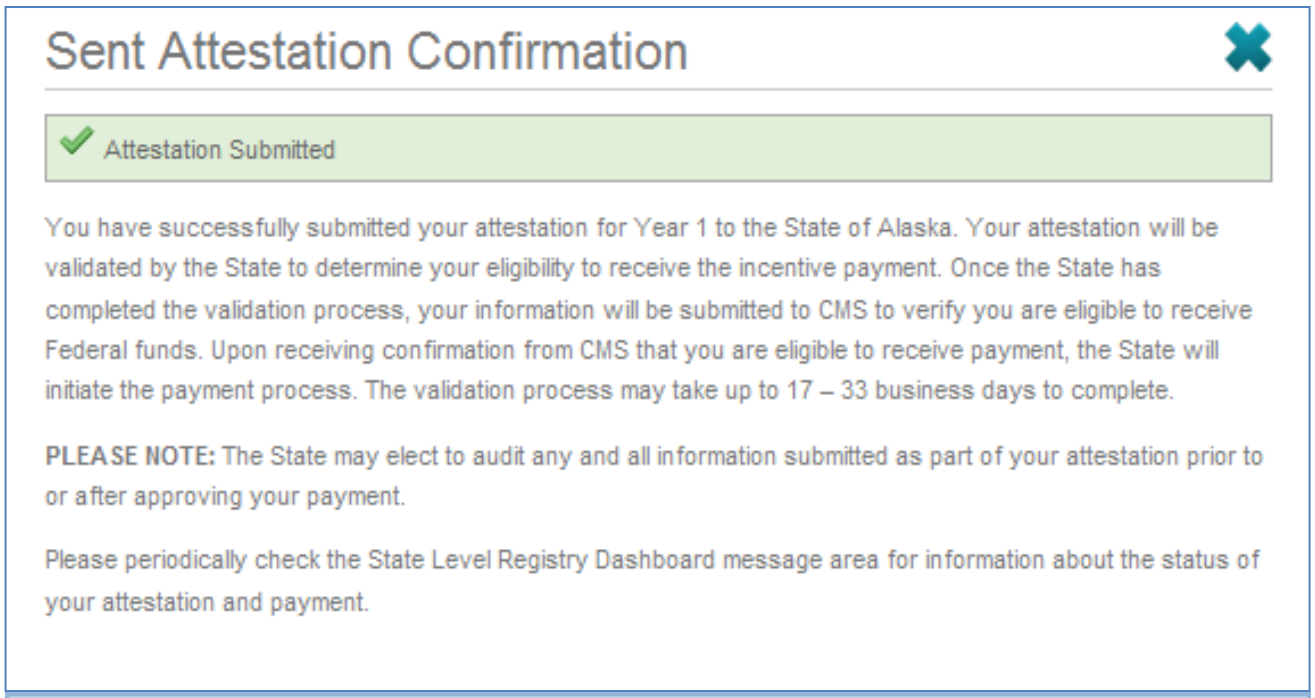
Send Attestation



To complete the attestation you must send the attestation and send the originally signed attestation agreement to:

State of Alaska
Department of Health and Social Services
EHR Incentive Program Office
1835 Bragaw St., Suite 300
Anchorage, Alaska 99508-3469

Send Year 1 Submission



Sent Attestation Confirmation – Once your attestation has been send, the SLR will provide a message that confirms that the attestation has been submitted

Year 1 Attestation Complete

13 Eligibility at a Glance

Qualifying Eligible Professionals (EP)		
1	Currently Enrolled with Alaska Medical Assistance	
2	Hospital-based EPs are NOT eligible	• 90% or more of services are performed in a hospital inpatient or emergency room setting.
3	Provider Type	• Physicians (MD, DO) ○ Pediatricians • Dentists • Certified Nurse Midwives Nurse Practitioners • Physician Assistants (PA) practicing at a FQHC/RHC so led by a PA
4	Patient Volume in a 90 day or greater period	• 30% Medicaid • 20-29% Medicaid - Pediatricians = 2/3 of incentive payment • 30% Needy Individuals Medical EPs practicing predominantly in FQHC or RHC

Qualifying Eligible Hospitals (EH)			
1	Currently Enrolled with Alaska Medical Assistance		

2	Hospital Types	Acute Care Hospital (includes CAHs & cancer hospitals)
		Children's Hospital
			• Avg. length of stay < 25 days
			• CCN last 4 of
			  ○ 0001 – 0879; 1300 – 1399
			  ○ 3300 – 3399
			Not applicable to children's wings of larger hospitals

3	Patient Volume over a 90 day or greater period	Acute Care Hospital Children's Hospitals	• 10%Medicaid • No Requirement

14 Definitions for the EHR Incentive Program

Acceptable documentation means satisfactorily completed written evidence of an approved phase of work or contract and acceptance of the evidence thereof by Alaska Medicaid. Acceptable documentation will refer to the certified EHR technology by name and will include financial and/or contractual commitment. Document date does not have to be within the preceding fiscal year, if the reported version of the EHR technology was certified after the document date. See examples below:

- Copy of contract
- Copy of invoice
- Copy of receipt
- Copy of purchase agreement
- Copy of user license agreement

Acute care hospital means a health care facility— (1) Where the average length of patient stay is 25 days or fewer; and (2) With a CMS certification number (previously known as the Medicare provider number) that has the last four digits in the series 0001–0879 or 1300–1399; or (3) Critical Access Hospitals

Adopt, implement, or upgrade (AIU) means— (1) Acquire, purchase, or secure access to certified EHR technology (proof of purchase or signed contract will be an acceptable indicator); (2) Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements; or (3) Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria.

Children's hospital means a separately certified children's hospital, either freestanding or hospital-within hospital that— (1) Has a CMS certification number, (previously known as the Medicare provider number), that has the last 4 digits in the series 3300–3399; and (2) Predominantly treats individuals less than 21 years of age.

Hospital-Based means a professional furnishes ninety percent (90%) or more of their Alaska Medicaid-covered professional services during the relevant EHR reporting period in a hospital setting, whether inpatient or emergency Room, through the use of the facilities and equipment of the hospital; verified by MMIS claims analysis.

Medicaid Encounter for an EP means services rendered to an individual on any one day where:

- Medicaid paid for part or all of the service; or
- Medicaid paid all or part of the individual's premiums, copayments, and cost-sharing.

Medicaid Encounter for an EH means services rendered to an individual per inpatient discharge or services rendered to an individual in an emergency room on any one day where:

- Medicaid paid for part or all of the service; or
- Medicaid paid all or part of the individual's premiums, copayments, and cost-sharing.

Medicaid Management Information System (MMIS) means the Medicaid claims payment system.

Needy individuals mean individuals that meet one of following:

- Were furnished medical assistance paid for by Title XIX Medicaid or Title XXI Children's Health Insurance Program funding including Alaska Medicaid, out-of-state Medicaid programs, or a Medicaid or CHIP demonstration project approved under section 1115 of the Act;
- Were furnished uncompensated care by the provider; or
- Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individuals' ability to pay

Patient volume means the proportion of an EPs or EHs patient encounters that qualify as a Medicaid encounter. This figure is estimated through a numerator and denominator and is defined as:

- [Total (Medicaid) patient encounters in any representative continuous 90-day or greater period in the preceding calendar year/Total patient encounters in that same 90-day or greater period] * 100

Pediatrician means a Medical doctor who diagnoses, treats, examines, and prevents diseases and injuries in children. A pediatrician must (1) hold a valid, unrestricted medical license, **and** (2) hold a board certification in Pediatrics through either the American Board of Pediatrics (ABP) or the American Osteopathic Board of Pediatrics (AOBP).

Practices predominantly means an EP for whom more than 50 percent of his or her total patient encounters occur at a federally qualified health center or rural health clinic. The calculation is based on a period of 6 months in the most recent calendar year.

State Medicaid HIT Plan (SMHP) means a document that describes the State's current and future HIT activities.

Appeals Form

Provider Information

Provider Name: _____

Organization Name (if any): _____

Medicaid Provider ID: _____NPI No: _____

Contact Name: _____

Contact Telephone No: _____

Mailing Address:

_____

City State Zip

Reason for Request

Please give a complete explanation for the appeal reason (i.e., denial of payment, eligibility determination, AIU or MU). Attach copies of any documents that support the appeal.

_____

_____

_____

_____

_____

_____

(Attach additional paper if necessary)

PLEASE SEND THIS FORM TO:

Department of Health and Social Services
Division of Health Care Services
EHR Incentive Program Office
1835 Bragaw Street, Suite 300
Anchorage, Alaska 99508-3469

EHR Incentive Program Office Fax #: 907-334-2566
For questions email: hss.hitinfo@alaska.gov